Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the *Mental Health Act*

For the Ontario Ministry of Health and Long-Term Care

Dreezer & Dreezer Inc.

December 2005

Acknowledgements

This report could not have been produced without the hundreds of hours of time contributed by a variety of people across the province. While the individuals and groups with whom we met often held opposing views on issues, they shared a passion for promoting the dignity and health of those suffering from serious and persistent mental illness.

We wish, therefore, to extend our gratitude to all of the experts on community treatment orders and mental health legal issues who gave of their time to facilitate our research and make this report possible. Among those experts to whom a special debt of thanks is owed, we wish to mention the community treatment order clients and other consumers, family members, psychiatrists and other mental health professionals, assertive community treatment team members, lawyers, tribunal members, judges, parole and police officers, and government officials who made themselves available to us and willingly shared with us their expertise, experience and considered opinions. We hope that this report faithfully reflects their views and experience.

We wish to extend our particular thanks to the community treatment order coordinators across the province. They provided us with invaluable assistance in facilitating our consultations in every corner of Ontario.

The Consulting Team

The Ontario Ministry of Health and Long-Term Care contracted the review to Dreezer & Dreezer Inc. A three-person team undertook the review. While each team member was responsible for a major function of the review, the findings, conclusions and recommendations were written collaboratively and represent a merging of their collective findings. A summary of the team members' backgrounds follows.

Stephen Dreezer, CA

Stephen Dreezer coordinated the review and carried out the data collection and analysis.

He is a chartered accountant and management consultant. He worked for the Ontario Public Service (OPS) from 1968 to 1990. His Ontario Ministry of Health career spanned the years 1969 to 1988, during which time he was the Ministry's Executive Director, Finance and Administration (1976-1986) and the Executive Director, Institutional Division (1986-1988). Since leaving the OPS in 1990, he has undertaken a wide range of public sector consulting assignments.

Michael Bay, JD

Michael Bay carried out the interview segment of the review.

He is a lawyer with extensive mental health experience. From 1995-2002 he was the first Chair and CEO, of Ontario's Consent and Capacity Board; from 1998-2000 he was Director, Mental Health Law Education Project; from 1993-1994 he was Implementation Coordinator, Consent and Capacity Board; in 1989 he had a six-month assignment by the Minister of Health to study and report on the structure, organization and future of the Psychiatric Review Boards; from 1989-1995 he was Chair, Psychiatric Review Board (Toronto West); from 1988-1989 he was mental health counsel with the Legal Services Branch of the Ministry of Health; and in 1988 he was Executive Assistant to the Minister of Health. He is currently in private practice devoted to education, consultation, dispute resolution, health law and administrative law and is an assistant professor (PT) in the Department of Psychiatry and Neurosciences at McMaster University.

David Hoff, BA, MA, MPH

David Hoff carried out the literature review.

He has held hospital management positions, consultant roles with the Ontario Ministry of Health and has had teaching roles with universities and professional associations. He was an adjudicator with the Ontario Consent and Capacity Board from 2002 to 2005 and has had a management consulting practice since 2001.

From 1981 to 2001 he worked for the Ministry of Health, including: Director, Transition Project, Consent and Capacity Board, 1999-2001; Acting Chief Operating Officer, Ontario Review Board, 1999; Manager, Legislation Policy Unit and Strategic Priorities Resources Group, 1996-1999; Senior Adviser, Health Strategies Office, Ministry of Health, 1995-1996; Executive Director (Secondment), Halton District Health Council, 1993-1994; Director, Research, Evaluation and Intergovernmental Affairs Branch, 1992; Director, Training and Research Branch,1990-1992; Director, Policy Development Branch, 1989-1990; Area Planning Coordinator, Central West Area, District Health Council Program, 1986-1989.

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Hon. George Smitherman
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister:

We are pleased to submit our report on the first legislated review of community treatment orders (CTOs) in Ontario. Section 33.9 of the *Mental Health Act* requires the Minister to establish a process to review the following three matters:

- The reasons that community treatment orders were or were not used during the review period
- The effectiveness of community treatment orders during the review period.
- Methods used to evaluate the outcome of any treatment used under community treatment orders.

In addition, we were requested to review:
- The mechanisms and the effectiveness for provision of rights advice
- The prevalence and effectiveness of the use of leaves of absence as an alternative to CTOs.

We undertook, based on our findings from the review, to provide recommendations for improvements to the CTO processes and also to make recommendations designed to enhance the quality of the next review due five years hence.

Michael Bay, David Hoff and I would be pleased to meet with you and your officials to discuss our report.

Yours truly,

Stephen Dreezer, CA
President

1.0 Executive Summary

1.1 Overview

As explained below, section 33.9 of the *Mental Health Act* requires this review. The review has a limited scope and, as a result, it does not take the place of valid, properly structured research. Having said that, however, many of our findings are consistent with the literature on CTOs in Canada and elsewhere.

It is undeniable that CTOs have benefited many individuals and their families. While our review identifies some operational problems and issues with the use of CTOs as a treatment modality for persons who would otherwise be detained in a psychiatric facility, CTOs clearly have a place in the treatment options that are available to health care providers and some of their patients. The benefits of a CTO are not dissimilar to those of any other community mental health program, and the requirements for success are the same in many respects. For example, the key findings of the Community Mental Health Evaluation Initiative (*Making a Difference, Ontario's Community Mental Health Evaluation Initiative*, October 2004 – www.ontario.cmha.ca/cmhei) include the following statement: "Housing, employment, income and health care supports are essential to maintaining the health and well-being of people with serious mental illness." This is as true for CTO clients as it is for clients of other community mental health programs.

From the outset of our review we wanted to avoid creating a report that contained the long list of recommendations that many other similar reports contain, and that we believe often leads to implementation inertia. However, the many differing and often contradictory opinions that we heard first hand or read about led us to make a fairly lengthy series of recommendations that focus on improving the way that CTOs work. In order to make them manageable for policy-makers, we organized them under five headings: administrative and regulatory changes; necessary research; legislative changes; changes to rights advice and leaves of absence; and the next legislated review. This grouping separates most of those changes that can be implemented without opening the legislation from those that require legislative change.

Our findings and recommendations will almost certainly find both supporters and detractors because that is the nature of the debate about CTOs. For example, those who would like to see CTOs abolished completely because they see CTOs as violating an individual's rights would probably still want to see them abolished.

What became clear to us very early on in our review is that CTOs are just one treatment modality among the many that are available to help those persons who need treatment and support to deal with their mental illness. While the provision in the *Mental Health Act* that requires a CTO review to be carried out on a regular basis is unique in Ontario and a progressive requirement, it is unfortunate that it deals with only three matters and that they are limited to the study of CTOs. The Ministry of Health and Long-Term Care (MOHLTC) asked us to expand the scope of our review to encompass additional questions. However, we recommend that the scope of the review due five years hence be expanded even further to encompass all community mental health programs, related community support services, the use of leaves of absence, rights advice, etc. – including CTOs. The rationale for this is covered in the report. However, its essence is that CTOs form part of the community mental health care spectrum and are, or are not, used for a variety of reasons related to that fact, including as a way to obtain services that would otherwise not be available.

Our report highlights and makes recommendations about a number of other key matters. These include the paucity of research around the coerciveness inherent in CTOs versus the need to receive treatment, and the dilemma that this creates; the many enforcement issues that create problems for psychiatrists and law enforcement agencies and that do not necessarily serve the best interests of the CTO client; broadening the role of CTO coordinators to improve the management of the CTO process; and the problems in obtaining timely, accurate and complete data.

1.2 Background

In Ontario, community treatment orders (CTOs) are a treatment option established under sections 33.1 to 33.8 of the *Mental Health Act*, which came into force on December 1, 2000.

Section 33.9 of the act requires the Minister of Health and Long-Term Care to establish a process to review:
a) the reasons that community treatment orders were or were not used
b) the effectiveness of community treatment orders during the review period
c) methods used to evaluate the outcome of any treatment used under community treatment orders.

The legislation requires that these reviews be repeated every five years subsequent to this, the first review.

The MOHLTC retained a three-person team from Dreezer & Dreezer Inc. to undertake the review. The consultants are: Stephen Dreezer, CA; Michael Bay, JD; and David Hoff.

In addition to the statutory questions, the MOHLTC requested that the team answer the following eleven sub-questions:

The reasons that CTOs were or were not used during the review period

- What factors affect clients' decisions to use/accept a CTO?
- What factors affect physicians' decisions to use/accept a CTO?
- What factors affect substitute decision-makers' decisions to use/accept a CTO?
- What alternatives to CTOs are being used to manage clients in the community?
- What are the characteristics of clients using CTOs?
- Where are the CTOs originating?

The effectiveness of CTOs during the review period

- What effect do CTOs have on client well-being and satisfaction?
- What services and supports are CTO clients receiving?
- What are the factors impacting on the effectiveness of CTOs?

Methods used to evaluate the outcome of any treatment used under CTOs

- What client outcomes are being measured?
- How are client outcomes being measured?

and two additional questions:
- The mechanisms and the effectiveness for provision of rights advice.
- The prevalence and effectiveness of the use of leaves of absence (LOA) as an alternative to CTOs.

The scope of the review was also to include recommendations that would improve CTOs, their evaluation, and support the next review.

The period covered by the review was December 1, 2000 to December 31, 2003. We also collected CTO activity data for 2004 to establish whether there was a continuing pattern to the use of CTOs.

We used a multi-dimensional approach for the review. We undertook, concurrently, interviews/surveys with a wide range of stakeholders, a literature review, and data collection/analysis. The results were reviewed and our findings were summarized under each of the statutory and supplementary questions. We then developed our conclusions and recommendations.

Even before we commenced the review, it was known that there were a number of issues that would make it difficult to evaluate the impact of CTOs. For example, the difficulty in identifying who to talk to and the reticence of many individuals to share their problems, questionable data quality and data gaps, and the fact that CTOs are one treatment modality among many and there are many reasons why they may be used, e.g., to gain access to services that otherwise would not be available. Notwithstanding these problems, we believe that sufficient information was made available to us to support our recommendations.

1.3 Literature Review

The literature review is dealt with in section 3.0 of the report. We were able to identify many useful articles and books, and some critical appraisals. We reviewed the CTO structure in other jurisdictions within Canada and also New Zealand, Australia, Scotland, England and Wales, Israel, and the U.S.A. Our report includes summaries of the criteria used in each jurisdiction, the administrative structure and procedures, the allocation of powers and the consequences for patients, and the rate of use.

We were particularly interested to see if there was any clinical trial evidence to support or refute the benefits of CTOs as against other treatment modalities – especially community care.

We focused on the only two comprehensive reviews of the research evidence relating to the effectiveness of involuntary outpatient treatment that we could find. These were by the RAND Corporation and by The Cochrane Collaboration. Both of these studies looked at the same two randomized clinical trials of involuntary outpatient treatment that were conducted in New York City and in North Carolina. In neither case were they able to state that compulsory community treatment was any more effective than similarly intensive care without the compulsion. The bottom line is the need for more research.

Because it was a central theme in the literature that we reviewed, we have summarized the debate in the literature about coercion. The key dilemma is that of the rights that a patient has to give up in order to benefit from community care, when perhaps in nearly all cases the same benefits can be obtained without coercion. Other related concerns are the potentially negative impact of coercion on the patient/clinician relationship and on an individual's willingness to seek care.

1.4 Data

Data is dealt with in section 4.0 of the report. We accessed data collected by the MOHLTC through its mental health, public hospital, and Ontario Health Insurance Plan (OHIP) systems. Additional data on CTOs was provided by hospital and community mental health organizations that support CTO clients. We also collected some data about patients who are receiving community care outside of a CTO, and data on leaves of absence from psychiatric facilities. Lastly, we opened a project website and placed a survey on it so that anyone who had an interest in CTOs could respond either online or by completing a paper copy of the survey and mailing it to us. The survey was designed once a significant number of interviews had taken place and it, therefore, was used to address many of the issues raised in the interviews. Several hundred agencies were advised by the MOHLTC of the website and the survey so that they could inform their client group of its existence.

We attempted to develop as comprehensive as possible a picture of CTOs by linking data using a CTO client's initials, date of birth and gender. The raw data has been reviewed by only one of the consultants and has not been shared with anyone else. CTO client anonymity was protected and legal privacy safeguards were observed.

We discovered gaps in the data, and data scope and quality problems.

The two major CTO data collection forms used by the MOHLTC in its mental health and OHIP groups were designed in anticipation of the review. Because they are stand-alone reports (their submission, or the omission thereof, has no consequences) compliance is less than 100 percent. There were physicians who billed OHIP for CTO-related services who did not submit the required supplementary CTO information forms to OHIP. There were OHIP billings for CTO issue and renewal services for which there was no record in the MOHLTC CTO database, because the appropriate hospital or community agency staff person had not submitted the required form. We were also told of physicians who avoided the ministry's CTO forms by billing OHIP under alternative fee schedule codes. There is no standardized form of quality control, either at source or within the MOHLTC.

The MOHLTC also collects potentially relevant data through its hospital daily census summary reports (leaves of absence), through physicians' sessional fee reports, and through standardized community mental health agency reporting. However, because the data of interest from the CTO review perspective represents a small subset within the reporting program, the MOHLTC does not require it to be broken out.

In addition to the foregoing data sources, many CTO coordinators were able to provide us with data that included additional demographic data about CTO clients to that collected by the MOHLTC, e.g., race, language, education, and employment.

We also received CTO-related activity data from the Psychiatric Patient Advocate Office (PPAO) and from the Consent and Capacity Board (CCB).

From all of this data we were able to produce some general profiles of CTO clients, the care that they received and the use of CTOs in the various regions of Ontario. We were also able to identify some of the reasons why CTOs were not used for particular individuals. We produced summaries of the data/information that we were able to collect on CTO renewals and reissues, leaves of absence, and the timing of rights advice and CCB hearings.

Because of the small number of individuals who responded to the web survey, and the fact that their responses were consistent with those of the interviewees, we combined their responses in section 5 of the report.

1.5 Interviews

The interviews are dealt with in section 5.0 of the report. We conducted over 250 individual and group interviews, involving over 1,000 individuals. The interviews included 47 CTO clients, 93 consumer advocates and representatives, 84 family members and 216 psychiatrists. We also met with CTO coordinators, representatives of various associations with an interest in CTOs, and representatives of the justice system. We were impressed by how open and frank people were.

We visited all regions of Ontario and interviewed people in 45 communities.

The responses we received to our questions, even from within a category of interviewees, represented many different points of view. We have summarized them in sections 5.1 to 5.30 of the report. They deal with client, family and substitute decision-maker feelings about CTOs and the processes involved; about issues of concern to the aboriginal and multicultural communities; about the perspectives of psychiatrists, CTO coordinators, and the police and other players in the justice system; and the issues for rural Ontario.

Concerns included the use of the term "Brian's Law"; the breadth of community treatment plans; the lack of quality assurance and consistency across Ontario; voluntary consent, civil liberty and the lack of a least restrictive alternative approach; the technical requirements to issue a CTO and the paperwork involved; rights advice and the CCB process.

We heard about hospital leaves of absence, discharge planning and hospital/community partnerships; the role of education; the need to focus on wellness and housing, employment and other community supports; the infrequent use of CTOs outside of a Schedule 1 psychiatric facility and for young people; and were able to identify best practice areas of Ontario.

1.6 Findings

Our findings are dealt with in section 7.0 of the report. We structured our findings around the statutory and additional questions.

The reasons that CTOs were or were not used during the review period

There is no data on the reasons that CTOs were used or not used. Also, this is a topic that is not definitively addressed in the literature. We, therefore, had to rely on the results of our interviews in order to answer these questions.

What factors affect clients' decisions to use/accept a CTO?

We received a wide range of responses to this question.

Clients' reasons for using/accepting CTOs included: a desire not to return to hospital; support to get over the rough spots; access to services; pressure from health providers; incapable acquiescence; desire to avoid future hospitalization; and satisfaction with a previous CTO.

On the other hand, clients' reasons for not using/accepting CTOs included: a lack of insight into their situation; concerns with autonomy and dignity; dissatisfaction with a substitute decision-maker; and belief that they are ready to move on.

What factors affect physicians' decisions to use/accept a CTO?

The reasons that physicians use or do not use CTOs are complex and inter-related, varying from the philosophical or ideological to the very practical. They vary from physician to physician and between jurisdictions, especially as the rules for CTOs differ between jurisdictions.

The reasons that physicians used CTOs included: belief in the righteousness of CTOs; belief in the efficacy of CTOs; availability of organizational resources; family insistence; access to resources; encouragement and mentoring; the availability and assistance of the CTO coordinator; and being a salaried physician.

The contrary view included: concerns with the enforcement process; negative experience with Consent and Capacity Board process and hearings; the requirement that the patient meet the *Mental Health Act*'s Form 1 criteria (Application by Physician for Psychiatric Assessment); a perceived "lack of teeth", e.g., the ability to force medication; concerns with the complexity and amount of time required to institute a CTO; dearth of suitable candidates; concerns regarding legal liability; a belief that CTOs are or may be a violation of the rights of their patients; a belief that CTOs are redundant given the range of treatment modalities available; concerns for the trusting relationship between the patient and the physician; lack of resources in certain parts of the province; lack of support for community physicians; a belief that more money can be earned doing other things; lack of mentoring and encouragement; the six-month length of CTOs is too short; lack of knowledge about and familiarity with CTOs; the requirement for prior hospitalization; lack of a belief in the efficacy of CTOs; inertia; capable clients refusing consent; clients being discharged from hospital prior to a CTO being put in place; lack of access to physician for community follow-up; and CTOs are sometimes not renewed because the physician is of the view that maximum benefit has been derived, or that the previous CTO has failed.

It should be noted that psychiatrists who were not using CTOs were much less willing to speak with us than psychiatrists who used them. While this was clearly a limiting factor in our work, we believe that we have gained a reliable picture of the reasons that psychiatrists may shy away from using CTOs.

What factors affect substitute decision-makers' decisions to use/accept a CTO?

The reasons that substitute decision-makers (SDM) consented to a CTO included: the CTO was recommended by the health care team, and either they felt pressured or they normally go along with professional recommendations without question; they were desperate after many years of trying to get help; the CTO was seen as a way of playing a role and obtaining leverage; the CTO was a way to get access to information; they agree with the concept of outpatient committal; and they had a positive experience with a previous CTO.

Reasons for non-acceptance included: that they refused to make themselves available to meet with the rights adviser; a belief that CTOs are an affront to the dignity of the subject person; concern about the potential for a rupture in their personal relationship with the individual under a CTO; less than satisfactory experience with the mental health system; and problems with rights advice.

Other factors affecting a SDM's decision included: the decision-making rules in the *Health Care Consent Act*; their perception about whether the client is willing/able to comply; their willingness to assume the responsibility; and their perception of the availability of resources.

What alternatives to CTOs are being used to manage clients in the community?

Assertive community treatment (ACT) teams and other forms of comprehensive case management in the community are the most common alternative to CTOs. Sometimes, as in Chatham, CTOs are not used because of the close working relationship between the hospital and community service providers. Some clients find themselves in the criminal justice system, because they do not receive community mental health services, or there is poor liaison between the health and justice systems.

Beyond their basic mental health care needs, community agencies form a rich mosaic of services and service philosophies that are available to individuals across Ontario. There are consumer-run businesses and drop-in centres that provide peer support and a myriad of other services that operate in a non-threatening and supportive environment.

What are the characteristics of clients using CTOs?

There is no such person as a typical CTO client. There are, however, some common themes and similarities. They all have a track record of treatable mental illness and meet the legislated criteria for a CTO in the *Mental Health Act*.

Just over half of CTO clients are male and just under half are female. A very small minority is young or elderly, and approximately 70 per cent are aged 21 to 50. A similar percentage of CTO clients are diagnosed as suffering from schizophrenia and about 30 per cent suffer from schizoaffective disorder or bipolar disorder. Very few are diagnosed as suffering from other disorders.

CTO clients tend to be individuals who are seen as likely to comply with their CTO, and about half are considered to be capable of consenting to their own treatment. It has been suggested that many of these clients are notionally capable.

Where are CTOs originating?

CTOs are almost exclusively originating in Schedule 1 psychiatric facilities. A small number of family physicians in the community have initiated CTOs, but many of these "experiments" have been abandoned by the physician as unworkable. Some ACT teams have initiated CTOs in the community and have found the results to be satisfactory, but this practice does not appear to be widespread. To a large extent, the hospital focus is the result of infrastructure and resource availability.

Geographically, CTO usage is uneven across the province. There are many reasons for this including physician preference, the availability of case management and other necessary services, the CTO coordinator being on-site in the hospital, the quality of the relationship between the hospital and agencies in the community, and the participation of the CTO coordinator and community agency representatives in discharge planning.

The effectiveness of CTOs during the review period

What effect do CTOs have on client well-being and satisfaction?

Other than a small number of local Ontario studies, there was no quantitative data available that addresses the issue of client well-being and satisfaction. Our review of the literature indicated that most studies concentrated on factors other than client well-being and satisfaction. However, one New Zealand interview study of Maori CTOs did indicate an improved perception of well-being and satisfaction.

We often heard that CTO clients experienced substantial improvement in a number of spheres, including: a level of stability that allowed them to stay outside of hospital; a welcome level of personal support and attention; continued treatment during periods of severely diminished insight; the ability to find stable housing, complete education and reintegrate into the community.

Many family members reported substantial improvement in the CTO client and a related improvement in the problems that the illness creates for the family.

On the other hand, some clients and advocates feel that any benefits are outweighed by the loss of personal autonomy and control. Some physicians saw little, if any, benefit from using CTOs but this was not the case for the majority who did use CTOs for their patients.

What services and supports are CTO clients receiving?

The data collected by the MOHLTC indicates that a wide range of services are being made available to CTO clients, including: hospital outpatient psychiatry/mental health programs; assertive community treatment (ACT); addiction service; crisis intervention; case management; private psychiatrist; medication management/clinic; supportive housing; non-psychiatric medical care; community mental health services through a specified agency; a physician for injections/depot injection clinic; a court diversion program; occupational therapy; counselling; forensic services; self-esteem/anger management; the Public Guardian and Trustee or other trustee for finances; and shelter while waiting for supportive housing.

The use of these services depends on the needs of the CTO client, the availability of the services in the community, and the relationship between the hospital initiating the CTO and the local community agencies.

What are the factors impacting on the effectiveness of CTOs?

It is not possible to provide a definitive answer to this question. CTO clients receive a high level of service, but are also subject to substantial legal restrictions. In the Chatham area these services are provided outside of a CTO. It is clear that the services are of benefit whether provided within a CTO and its community treatment plan, or outside of a CTO. What we are unable to conclude with respect to an individual client or to a group of clients is which, if any, of the benefits of a CTO derive from the legal restraints placed upon CTO clients as opposed to the services, increased professional accountability and level of professional organization devoted to their care.

Methods used to evaluate the outcome of any treatment used under CTOs

What client outcomes are being measured?

The MOHLTC collects data on a CTO client's use of services during the six months before the current CTO, on the services to be involved in the current CTO, on a CTO client's involvement with the legal system during the six months before the current CTO, on who a CTO client lives with and the type of housing occupied by a CTO client. These are some of the factors that address client outcomes.

While a CTO client's support team monitors their progress, there is no system-wide evaluation of outcomes.

A few small local studies have attempted to measure client outcomes. They measure such intangibles as satisfaction, and compare hospitalization rates, legal involvement, type of housing, income and employment, etc. both before and after the CTO. However, they cannot be used as the basis for Ontario-wide conclusions.

How are client outcomes being measured?

The MOHLTC has a limited view of client outcomes that is restricted to the services that they receive, their involvement with the legal system and their living arrangements.

Client outcomes are generally measured on an ad hoc basis using two major approaches, i.e., through monitoring an individual's data, and on a collective basis through file review and questionnaires and other survey tools.

Mechanisms and the effectiveness for provision of rights advice

The Psychiatric Patient Advocate Office (PPAO) provides the vast majority of CTO-related rights advice. A very few and decreasing number of hospitals have their own rights advisers.

The *Mental Health Act* requires a physician to provide notice of his or her intention to issue a CTO, and this notice initiates the provision of advice on an individual's legal rights. These rights include the right to retain counsel and the right to request a Consent and Capacity Board review. Rights advice must be provided between the time that the community treatment plan is proposed and the time that it is signed, although the proposed CTO client can refuse to receive rights advice. Rights advice must be given to the substitute decision-maker, if any, and a person who refuses to receive rights advice is not entitled to act as a substitute decision-maker.

CTO rights advice is generally provided in person, but occasionally the telephone is used to provide advice to substitute decision-makers. It would appear that resource, staffing, and logistical issues dictate this practice.

The rights advice process appears to be working very well. Most people that we spoke to told us that they are satisfied with the process. Rights advisers were generally described as professional and knowledgeable.

Some concerns did, however, surface during our consultation process. These relate to such things as: less than full cooperation with and unreasonable demands (e.g., requests for late night advice) of rights advisers; comprehension problems with telephone advice; six-month repetitions when a CTO is renewed regularly, and rights advice for officials of the Public Guardian and Trustee officials every time that they act as an SDM; some delays in providing rights advice, although the PPAO does its best within the resource base provided to provide rights advice as quickly as possible.

Two of the PPAO's practices were of greater significance. These are:

- PPAO policy prevents rights advisers from advising the physician or hospital when a patient applies to the Consent and Capacity Board. While the PPAO believes that the practice is justified in order to protect client confidentiality, it is at variance with accepted norms in the legal world. It causes administrative difficulties by preventing the physician and hospital from finding out about a pending hearing until close to the date when it will take place. It also causes a great deal of unneeded resentment on the part of health professionals.

- The PPAO rights advice process routinely goes beyond the straightforward information-giving dictated by legislation and tradition. The PPAO requires a copy of the proposed treatment plan for review by their head office before rights advice is given. It is their position that this is done in order to allow them to prepare to provide rights advice. We heard, however, from health and helping professionals across the province that the PPAO routinely intercedes directly with the professionals when it feels that elements of the treatment plan are not acceptable. While we were told by the PPAO that this is being done to fill a void by providing non-binding input, it is taken as binding direction by many CTO coordinators, etc. and affects their decisions. There appears to be no statutory authority for this practice.

Prevalence and effectiveness of the use of leaves of absence (LOAs) as an alternative to CTOs

Because the Ontario data on the use of leaves of absence is inconsistent and incomplete, we were not able to produce a picture of their utilization. Also, the literature does not fill this void in any significant way. Several jurisdictions use leaves of absence with or without conditions, but we are not aware of any studies that draw definitive conclusions after comparing the use of leaves of absence with the use of CTOs.

Historically, leaves of absence have not been widely used in Ontario. They were generally used for weekend passes and the like. They were also sometimes used to prepare a patient for discharge into the community or as a means of gauging suitability for discharge.

The June 2000, amendments to the *Mental Health Act* significantly strengthened the leave of absence provisions in two important ways:

- The requirement that there be an intention that "the patient shall return to the facility" was removed. Thus, nothing would appear to prevent the use of a leave of absence as a bridge to community reintegration or the use of successive leaves of absence as an alternative to a CTO.
- Either the attending physician or the officer in charge may now grant leaves of absence. The attending physician, however, may only grant a leave if it is the intention that the patient shall return to the facility. It should also be noted that, whether the officer in charge or the attending physician grants the leave, only the officer in charge can impose terms and conditions on the leave.

While there are significant differences between the use of a CTO and a leave of absence, there are some similarities. A leave of absence may be used with a voluntary, involuntary, or informal patient. However, they are only enforceable with regards to the involuntary or informal patient. In these cases, conditions could be attached to a leave of absence that would allow the use of the police to return the patient in the same manner as any other patient who is unlawfully at large from the facility.

Placing a patient on a leave of absence does not give rise to a visit by the rights adviser or the right to apply to the Consent and Capacity Board for a review, although involuntary and informal patients are entitled to rights advice and a board hearing by virtue of their status. Voluntary patients do not receive either rights advice or the right to a hearing.

A leave of absence does not require a community treatment plan with defined roles for the various agencies and professionals or provide access to the CTO coordinator, a fast track to case management or enhanced access to other community services.

If the goal of the June 2000 amendments was to facilitate the much wider use of leaves of absence in the province, it has not happened. In fact, with very few exceptions the psychiatrists, administrators and other professionals with whom we spoke were not aware of the amendments to the leave of absence provisions.

There are an additional three factors that impede the use of leaves of absence:

- the perceived requirement that a bed be kept available for a patient who is out of the hospital on a leave of absence
- the wide-spread belief that individuals released on a leave of absence are not entitled to income support under the Ontario Disability Support Program (ODSP), even though government policy clearly specifies that patients who are in the community on a leave of absence under the *Mental Health Act* are not to be denied ODSP for that reason
- the belief on the part of some practitioners that the use of leaves of absence could result in enhanced legal liability.

1.7 Recommendations

As we reflected on what we had read and heard, we concluded that CTOs have helped many people, notwithstanding the many issues and concerns that need to be dealt with. On the other hand, we learned that some CTOs have been put in place in a way that avoids the spirit, if not the letter of the law. Our challenge was to make recommendations that will improve upon the use of CTOs and ensure that alternative treatment modalities are used when more appropriate.

The recommendations are listed in section 8.3 of the report. We divided our recommendations into five parts. There are recommendations regarding:

- changes that could be made administratively or by a change in regulations
- research
- changes that should be considered when the *Mental Health Act* is next opened for amendments
- rights advice and leaves of absence
- the next review.

Each one of our recommendations will help improve the use and administration of CTOs and/or the quality of life of CTO clients. However, there are five issues that we identified as being of major concern. These are:

- legal coercion and research
- enforcement
- the role of CTO coordinators
- data
- the scope of the next review.

Legal coercion and research

While a CTO is theoretically entered into voluntarily, once in force it takes on the nature of compulsory treatment. It requires the CTO client to either comply fully with the community treatment plan or else be subject to being taken by the police to the named physician under the Form 47 process. In some cases, individuals are directly or indirectly coerced into agreeing to a CTO.

Interestingly, accountability for complying with the conditions of the community treatment plan rests entirely on the shoulders of the CTO client. Even though the legislation requires service providers to accept responsibility for implementing the community treatment plan and providing the agreed upon services, there are really no consequences for their non-compliance.

However, this one-sidedness and the diminution in personal autonomy might be justified if a CTO is necessary for a successful outcome, if the likelihood of success is high, and if there is no reasonable alternative other than hospitalization.

Also, we know from the experience in Chatham that CTOs can be avoided (though perhaps not for all patients on an Ontario-wide basis) through a very close working relationship between hospital-based and community-based health care professionals, social services, etc. This type of close working relationship also exists in the Niagara Region and in Sault Ste. Marie, although CTOs are still used in those areas.

This creates a dilemma that currently has no obvious solution. The literature and the research carried out to date indicates that no-one has established whether the benefits that flow from a CTO are due to the coercive element, or the provision of intensive and wide-ranging community support services, or both, or some other factor(s); or whether coercion is a necessary component of a CTO for some individuals, but not others, and if so how you identify those that would benefit from a coercive component in their CTO. We concluded that this is an important area that needs to be carefully researched.

Enforcement

CTO enforcement was an issue raised at virtually every one of our meetings with health and helping professionals and police officials. They generally viewed the enforcement mechanism as deeply flawed.

The enforcement mechanism deals with the apprehension of the CTO client in the event of suspected non-compliance with the order, i.e., they have not attended appointments or have failed to comply with the community treatment plan. The physician completes Form 47, which provides authority for the police to apprehend the CTO

client and take them to the physician who signed the order. The physician must then examine the person in order to determine whether to execute a Form 1, enter into a new CTO or release the person without a CTO.

Professionals complained to us that they have been told that Form 47 automatically terminates the CTO (and the CCB has made rulings to this effect). The options at that point are to issue a new CTO, detain the person on the authority of a Form 1, or release the person into the community. As a result some physicians believe that "CTOs have no teeth" and this has influenced many of them not to use CTOs, or they find other methods of apprehension such as the use of Form 1, or are inclined to release the patient back into the community without a new CTO rather than go through the process of reissuing the CTO after apprehension on a Form 47. Some are also concerned that requiring that the client be returned to them, creates an unwarranted level of personal responsibility that potentially interferes with their ability to manage their practice and take time off, raises the level of legal exposure that they face, and causes problems if the client has moved from the local area.

A minority of professionals with whom we spoke believes that the act should allow for forced treatment in the event of non-compliance, either on site or in a hospital, otherwise CTOs are meaningless. Some felt that a "Tier 2 CTO" was necessary to deal with seriously ill individuals totally lacking in insight and the ability or willingness to cooperate with a treatment plan. However, a large number of professionals told us that forcing treatment under a CTO would alienate their clients, be an unjustified intrusion into the autonomy of these individuals and defeat their main purpose of which is to build a relationship of trust with the client.

Police forces had practical concerns about the enforcement process. They were sometimes reluctant to transport CTO clients over long distances or to take them to a specific physician rather than the closest hospital. As a result, various arrangements have been developed: passing an individual between two or more forces at their jurisdictional border; using paid off-duty officers to execute a Form 47 apprehension at the cost of the issuing hospital; taking the CTO client to the nearest hospital emergency department rather than to the hospital named in the Form 47. There was a concern about the frequent excessively long waits that police officers often experience at the hospital after apprehending a CTO client under a Form 47 while they wait for hospital staff to assume custody of the individual. They were also concerned about the lack of explicit authority for police to forcibly enter a dwelling house or other location during a Form 47 apprehension.

There is also a belief that many people suffering from serious mental illness could be, but are not being, diverted from the justice system to the mental health system with the assistance of a CTO.

There are, of course, differing opinions as to the significance of many of these issues, including some who believe that strong enforcement is the essence of the CTO process and that the success of CTOs is directly tied to the strength or weakness of the enforcement mechanism.

Changing the legislation to make it clear that the CTO continues after a Form 47 has been issued, unless the community treatment plan is modified by the physician, would provide necessary clarity, streamline the administration of the CTO, allow for continuity of care for the CTO client, and maintain the rights of the CTO client to require a CCB review or to simply withdraw consent for the CTO if they are not satisfied that the CTO is still necessary. Similarly, consideration should be given to allowing the police to take a CTO client to the responsible physician or designate, or to the closest Schedule I facility that would then be required to liaise with the responsible physician or designate.

The role of CTO coordinators

The CTO process is form and paper driven, unnecessarily complicated, and is sometimes difficult to understand. In addition, there is a requirement to file a variety of data reports with different parts of the MOHLTC – data that appears not to have been used for any day-to-day, value-added purpose. As a result of the foregoing:

- valuable physician time has been unnecessarily diverted to form filling
- some physicians have been dissuaded from using CTOs when their use would be indicated
- some inpatient stays have been extended at significant expense and inconvenience
- there are data quality problems.

The CTO coordinators act as the linchpin in the CTO process and have proven themselves to be an indispensable resource at all stages of the CTO process. They educate, coordinate, and facilitate the process. They provide essential assistance to physicians and are a key link between clients, families, hospitals, and community agencies. Many of them have accumulated a great deal of clinical and legal expertise related to CTOs.

We believe that they are not being used to their full potential. By modifying their role, the MOHLTC can bring about necessary improvements to the CTO processes by having CTO coordinators act as assurors of quality, consistency, compliance and practitioners of best practices.

We are of the view that, to facilitate discharge planning process and the collaboration between a hospital and the community agencies, CTO coordinators should be located in hospitals but should be employed by an appropriate community entity. This would allow them to fulfill an arm's-length quality assurance role, function as a community resource, and bring a wider community perspective to their work.

Our recommendations include the following:

The establishment of an overall facilitating function for CTO coordinators together with MOHLTC funding to: provide for their continuing education; to identify and promote best practices; collect reliable CTO data with regards to CTO usage and efficacy; to arrange for summary legal advice and direction for coordinators; and to define the role and qualifications for coordinators

CTO coordinators should be located in hospitals but should be employed by an appropriate community entity.

Coordinators should be designated under the regulations as persons who may review community treatment orders documents to ensure compliance with the act. They could be prescribed the additional duties of verifying and documenting on the face of the CTO whether or not all of the required conditions were met and whether best practices were followed, e.g., less restrictive alternatives were considered for the client and the community treatment plan includes initiatives to facilitate wellness.

Consideration should also be given to the appointment of a small number of aboriginal CTO coordinators, with one in Northwestern Ontario and others in identified areas of the province. These coordinators should work in conjunction with the coordinators already in place.

We also believe that CTO coordinators should have a role in all Schedule 1 facility leaves of absence over 14 days to ensure that the leave provisions are properly planned and have a reasonable expectation for a positive outcome.

Data

Good data is necessary for a periodic review such as this. But it is more important still for program planning and for monitoring day-to-day operations. The MOHLTC's primary sources of data about CTOs were meant to be OHIP's *Community Treatment Order (CTO) Report Log* and the MOHLTC *Community Treatment Order (CTO) Information Record* forms. Other ministry systems collecting data that might be of use to a CTO program review do not collect the level of detail required. Data that is maintained by individual practitioners and agencies is defined locally, is therefore not uniform, and is not maintained in way that it can be easily transferred to the MOHLTC to provide a complete picture of use of CTOs.

We found that the CTO program suffers from: the need to redefine the data requirements; fragmentation of data sources; minimal or no use of the data that is collected leading to sub-optimal data quality; a lack of incentives/ disincentives for completeness, accuracy and timely transmission of data to the MOHLTC; and privacy concerns. These issues should be dealt with before the next review.

The types of data collected about CTO clients should support the recommended research and the requirements of the next review. The data collected by the Community Mental Health Evaluation Initiative, and the PSR Toolkit data that measures psychosocial rehabilitation outcomes, might provide useful starting points for discussion. They cover basic information on gender, age, education, marital status, employment/volunteering and finances, health/ illness and utilization of health services/medications, living arrangements, legal issues, etc. There is also information about community integration, participation in community services and support programs, social supports, quality of life, feelings about empowerment, coping, and so on. When data is collected over an extended period of time, it becomes invaluable in tracking changes that occur with respect to participating individuals and for program planning and research.

In our recommendations we suggest a stronger role for CTO coordinators. If this approach is implemented, CTO coordinators could become the custodians/coordinators of CTO data. This role would be enhanced if the MOHLTC were to provide them with local hardware and appropriate software that would allow them to: maintain their CTO-related records; edit and abstract required data and transmit it electronically to the MOHLTC; and produce reports

that would be both useful and of interest to those physicians and others involved in initiating or providing care through CTOs, as well as for overall planning and monitoring the CTO program.

The scope of the next review

As already stated, the scope of this review was narrowly defined and was centered on CTOs, leaves of absence and the provision of related rights advice. However, because CTOs are one treatment modality among the many that are available to health care practitioners, this narrow scope will always fail to explore the appropriate place of CTOs within the community mental health care world.

A broader scope review would not only provide more meaningful results, but would allow the MOHLTC to answer many questions that are common to CTOs and other community treatment modalities. For example: the relative use of hospital and community resources; the use of various types of community resources and the reasons why; the ability to function in the community; the care of individuals after a CTO; the part played by resources and their organization rather than the legal coercion aspect of CTOs; who is, and who is not, a suitable candidate for CTOs; and, do CTOs provide value for money?

2.0 Background

2.1 The Mental Health "System"

Ontario's mental health system falls under the jurisdiction of the Ministry of Health and Long-Term Care (MOHLTC) and dates back to 1850 when the first permanent asylum was opened in Toronto. During the next 100 years additional publicly owned and operated psychiatric hospitals were opened throughout Ontario.

Starting in the 1960s, following the earlier introduction of psychotropic drugs that reduced or controlled symptoms, significant numbers of patients began to be discharged from the psychiatric hospitals. Many moved into nursing homes and residential homes licensed under legislation to accept discharged psychiatric patients; into rooming houses and into other community accommodation; or were cared for by relatives and friends. Some were homeless. A network of community hospital psychiatric units, private hospitals, and other community services developed as an alternative to the provincial psychiatric hospitals.

While people commonly refer to Ontario's mental health services as a "system", in reality this is not the case. As the following diagram indicates, the mental health system is intricate. It has two major dimensions: the location, care needs and personal circumstances of the individual; and the treatment or care setting.

1. Examples of Diversity of Possible Program Settings

2. Patients/Clients	Hospital Inpatient	Hospital Outpatient	Hospital Leave of Absence	Community Treatment under a Community Treatment Order	ACT Team	Community Mental Health Program	Doctor's Office or Other Community Setting	Social Service Program	Informal Care (Family or Friends)	No Formal Care
Living in the community, not receiving care										
Living in the community, receiving care										
Hospital voluntary patient										
Hospital involuntary patient										
Held by justice/correctional systems (and possibly, the mental health system)										
In a hospital or the community by order of the Ontario Review Board										

Adding to this is the fact that the health care system within which mental health services are delivered is even more complex, for example:

With an individual's treatment and related care being determined and services provided by:

- themselves
- other lay individuals
- professionals, including teams

And services being provided in a myriad of:
- institutions
- other settings

Delivering services that are:
- limited in scope
- wide ranging

Through programs that are:
- formal
- informal

That are governed by:
- different federal and/or provincial ministries and legislation
- municipal regulation
- professional bodies
- volunteer boards of directors

And that are subject to evolving:
- public and professional attitudes
- rules
- guidelines
- statements of best practice
- research findings
- marketing efforts by suppliers of health care related goods and services.

As can be seen from the foregoing, community treatment orders are but one treatment modality among many. Whether it is the treatment modality of choice will depend on one or more of the factors within a series of complex interrelationships.

Moreover, two individuals who are living in the same community and who have exactly the same needs might well receive different types of care in different settings. Sometimes this is due to the availability or lack of local programs or access thereto; sometimes it is the result of a conventional or a random treatment or care decision by the health care provider or other caregiver or the individual or a third party; sometimes it results from other factors that are at play.

2.2 Legislation

In 2000, Bill 68 became law. It amended the *Mental Health Act* and the *Health Care Consent Act*. The short title of the act was *Brian's Law (Legislative Reform), 2000* after Brian Smith, an Ottawa sportscaster who was shot by a person who had been diagnosed with schizophrenia. While the legislation was prompted by this violent act, its real impact was to increase the range of available community treatment options.

The legislation and the related forms are available online at:
http://www.e-laws.gov.on.ca and http://www.forms.ssb.gov.on.ca.

2.3 CTO Legislated Processes

In order to provide a general understanding of the Ontario CTO process, the following table provides an overview of the various steps that form part of the legislated requirements. The table does not include all of the detailed legislated provisions. Therefore, the pertinent legislation and related legal decisions and rulings need to be studied in order to obtain a definitive understanding of all aspects of CTOs.

Table 1: Overview of the legislated CTO process

Step	Description
1	A health care worker(s) or another party believes that an individual might benefit from a CTO
2	Only a psychiatrist, a physician who practices in the area of mental health, or a physician who is an employee or staff member of a psychiatric facility can issue or renew a CTO
3	The physician must determine that, during the previous three years, the individual has been a patient in a psychiatric facility on two or more occasions or for at least 30 days in total, or has been the subject of a previous CTO
4	The physician must develop a community treatment plan by consulting with the health practitioners or other persons proposed to be named in the community treatment plan (the individual or his or her substitute decision-maker, physicians, and any other health practitioner or person involved in the person's treatment or care and supervision)
5	The physician must examine the individual within 72 hours before entering into the community treatment plan to establish: • the need for the care under the plan, and that the services are available • the likelihood of compliance • if not currently a patient in a psychiatric facility, the person is likely to cause serious bodily harm or suffer substantial deterioration or serious physical impairment
6	The physician completes Form 49 *Notice of Intention to Issue or Renew Community Treatment Order*, and gives to individual and, if one, the substitute decision-maker. The physician notifies the Psychiatric Patient Advocate Office (or the local hospital rights adviser). The form makes required declarations regarding the criteria for a CTO, and includes a notice of the entitlement to rights advice and the right to retain legal counsel about the CTO. The proposed community treatment plan must be attached.
7	A rights adviser contacts the individual and the substitute decision-maker (if applicable). Rights advice is provided or declined by the individual and provided to the substitute decision-maker (if applicable) and Form 50 *Confirmation of Rights Advice* is completed.
8	If the physician wishes to continue by issuing the CTO, Form 45 *Community Treatment Order* is completed. This form also contains the consent of the individual or the SDM, if any. The form is distributed to the individual and any substitute decision-maker, the officer in charge if a psychiatric facility is applicable, and any other health practitioner or person named in the community treatment plan.
9	Form 46 *Notice to Person of Issuance or Renewal of Community Treatment Order* must be given to the individual to advise them of their right to a hearing before the Consent and Capacity Board to inquire into whether the legislated criteria for issuing or renewing a CTO have been met and the right to retain legal counsel about the CTO at any time after it is issued or renewed.
10	If the individual or a person on their behalf wishes to apply to the Consent and Capacity Board for a hearing, they complete Part 1 of Form 48 *Application to Board to Review Community Treatment Order and Notice to Board by Physician of Need to Schedule Mandatory Review of Community Treatment Order*.
11	The Consent and Capacity Board holds a hearing and determines whether or not the criteria for issuing or renewing the CTO were met at the time of the hearing. Under the *Mental Health Act*, when a CTO is renewed for the second time and on every second renewal thereafter, a deemed application shall have been made by the individual subject to the CTO to the Consent and Capacity Board. The Physician is required to complete Part 2 of Form 48. This process does not apply to reissued CTOs. The board issues its decision using a standard format.
12	A CTO can be in effect for a period of up to six months. At that time it expires or it can be renewed within one month of expiring. In practice, if a CTO expires and is not renewed, and a new one is issued, the new CTO is classified by the MOHLTC for statistical purposes as a reissue.

Table 1: Overview of the legislated CTO process continued

Step	Description
13	If an individual does not comply with their CTO by: • failing to attend appointments • failing to comply with the treatment under the community treatment plan • failing to permit a physician to examine them within 72 hours of their withdrawal of consent to the community treatment plan and the physician has reasonable cause to believe that the criteria for issuing a CTO still apply and that the criteria for completion of Form 1 *Application by Physician for Psychiatric Assessment* apply, the physician completes Form 47 *Order for Examination*. A Form 47 is in force for 30 days and provides authority for a police officer to take the individual into custody and then to the physician who issued the Form 47.
14	After examining the individual, the physician can: • apply to have a psychiatric assessment of the individual • issue another CTO • release the individual without being subject to a CTO.

2.4 The Study

2.4.1 The Questions

The scope of this study is initially defined by the legislation that requires it to be carried out. Section 33.9 of the *Mental Health Act* requires the Minister of Health and Long-Term Care to establish a process to review three matters. On initiating the review, the Ministry of Health and Long-Term Care requested that we also answer a number of sub-questions, which are shown under each of the three legislated requirements:

1. The reasons that CTOs were or were not used during the review period
   What factors affect clients' decisions to use/accept a CTO?
   What factors affect physicians' decisions to use/accept a CTO?
   What factors affect substitute decision-makers' decisions to use/accept a CTO?
   What alternatives to CTOs are being used to manage clients in the community?
   What are the characteristics of clients using CTOs?
   Where are the CTOs originating?
2. The effectiveness of CTOs during the review period
   What effect do CTOs have on client well-being and satisfaction?
   What services and supports are CTO clients receiving?
   What are the factors impacting on the effectiveness of CTOs?
3. Methods used to evaluate the outcome of any treatment used under CTOs
   What client outcomes are being measured?
   How are client outcomes being measured?
   In addition, the ministry asked us to address the following two questions:
4. Mechanisms and the effectiveness for provision of rights advice
5. Prevalence and effectiveness of the use of leaves of absence (LOAs) as an alternative to CTOs.

   and we undertook to provide deliverables that included:
6. Recommendations which are clearly linked to the key findings and address opportunities to improve CTOs and enhance the capacity for monitoring and evaluating the CTO initiative (especially when compared to other treatment/care approaches)
7. Recommendations concerning methodology, data and other information aimed at improving the comprehensiveness and effectiveness of the next legislated CTO program review.

The review was to cover the period December 1, 2000 to December 31, 2003. However, we undertook to collect and review CTO activity data for 2004 to establish whether there was a continuing pattern to the use of CTOs.

2.4.2 The Review Methodology

Dreezer & Dreezer Inc. chose to use a multi-dimensional approach to collecting relevant information and data for the review. This included a literature review, the collection of quantitative data, the use of an online survey, and interviews with CTO clients, family, friends and substitute decision-makers, health care professionals, service/support agencies, law enforcement agencies, etc.

2.4.2.1 The literature review

The literature review provides an account of what has been published by established scholars and researchers relevant to evaluating CTOs. The purpose is to offer an overview of significant literature published on the topic. We have also incorporated an overview of the legislative schema of a number of jurisdictions and discussed relevant literature.

The literature review assessed and describes the knowledge base. It had the goals of (1) identifying a set of useful articles and books, as well as (2) critical appraisal to identify unbiased and valid studies, and (3) informing the approach to be taken in the overall project. We relied on existing literature reviews when possible. We focused on issues relevant to the Ontario circumstance.

2.4.2.2 Quantitative data

CTO-related data is collected by the Ministry of Health and Long-Term Care (MOHLTC), through its mental health and public hospital program areas and through the Ontario Health Insurance Plan (OHIP), and by the Consent and Capacity Boar by the Psychiatric Patient Advocate Office, and by various service providers, including CTO coordinators. We had hoped to be able to link the data from these various sources to provide a comprehensive view of the use of CTOs.

Not surprisingly, because of data fragmentation through:
- maintaining data in different agencies and in different parts of MOHLTC
- the lack of standardized data requirements and records

our database is incomplete. Notwithstanding this problem, the available data, especially that which we were able to link, does provide useful information about CTO-related activities and CTO clients. It also allowed us to identify data quality and data submission problems.

2.4.2.3 Interviews with CTO clients, family, friends and substitute decision-makers, health care professionals, service/support agencies, law enforcement agencies, etc.

During the course of the review we visited every region of Ontario in order to meet with and hear those with relevant expertise. Our experts included: psychiatrists and other health and helping professionals; CTO clients; other consumers and their advocates; family members and their advocates; government officials; and judges, lawyers, police officers, parole officers and other members of the legal and justice communities.

2.4.2.4 Limitations

From the outset of the review it was recognized that there are a number of realities that can skew the data/information and make it difficult to assess the true impact of CTOs. These include:

- the discomfort and reticence certain vulnerable people felt about discussing their health care problems with persons who were perceived as being in a position of power
- the relative difficulty in engaging professionals, clients, and families who are not involved in CTOs
- the problem of differentiating the effect of a CTO from the impact of the resources provided under the CTO
- some people will be placed/go under a CTO as only way to get resources
- some people are not under a CTO because they have access to adequate resources even though they qualify for a CTO
- some people may have access to adequate resources but still are under a CTO
- data and information sources are incomplete, incompatible and/or are unreliable.

While we used best efforts to ensure the accuracy of any data/information that we relied upon for our conclusions and recommendations, we have recognized these shortcomings and have included recommendations aimed at improving the quality of the data/information and the methodology that will be used in the next review.

3.0 Literature Review

The literature review provides a focused account of what has been published by scholars and researchers relevant to evaluating CTOs. The purpose is to offer an overview of significant literature published on the topic in so far as it assists with our task of responding to the questions set out in the legislation and to the additional questions which form part of this review.

The literature review is intended to (1) identify a set of useful articles and books (2) identify critical appraisal through unbiased and valid studies (3) inform the approach to be taken in the overall project. We relied on existing literature reviews whenever possible. We also focused on issues relevant to the Ontario circumstance.

The literature review is divided into four major sections.

- In the first section we look at the international scene, outlining the structure of the compulsory community treatment programs in a number of countries. We take that opportunity to highlight some of the literature on a jurisdiction-by-jurisdiction basis.
- In the second section we look at Canadian jurisdictions, again considering both the structure of compulsory community treatment programs and some relevant literature.
- The third section is devoted to a discussion of the two major reviews of clinical trial evidence on compulsory community treatment by RAND (Ridgely, M. Susan 2001)[1] and Cochrane (Kisely, S. 2005).
- The fourth section examines the literature on coercion.

3.1 CTO Structure in Other Jurisdictions

As can be seen, different countries have taken different approaches. Given that CTOs are only one of many possible forms of care and treatment available to mentally ill persons in countries where CTOs are used, it is very difficult to identify the strengths and weaknesses of the various national approaches to CTOs in isolation.

In establishing the relevance of the literature to Ontario it is important to recognize that:

- Countries like New Zealand, Australia and the United States do not operate in the same constitutional environment as we do here in Canada.
- There are significant differences in the legislative frameworks for compulsory community treatment across jurisdictions.
- The array of community services available to support community orders differs widely between and within jurisdictions.
- The funding schemes differ.
- Incentives and disincentives for health care practitioners, clients and families are different.

The tables included provide a comparative overview of the CTO processes used or proposed in New Zealand, Australia, Scotland, and England and Wales. The systems in Israel and the U.S.A. are also outlined. We summarize the criteria for a person to be covered by a CTO, the administrative structure, the procedures to be followed, the allocation of powers and responsibilities, the consequences for patients, and the rate of use. We have incorporated an overview of the literature on a jurisdiction-by-jurisdiction basis.

We are indebted to Professor John Dawson of the Faculty of Law, University of Otago, New Zealand, for permitting us to use the information contained in his recently published *Community Treatment Orders: International Comparisons* (Dawson, John 2005) in the tables.

[1] These are references to *Selected Bibliography* in section 9.1 of the report.

3.1.1 New Zealand

3.1.1.1 New Zealand legislation

Criteria for a person's cover by the scheme	Structure for its administration	Procedures to be followed	Allocation of powers and responsibilities under it	Consequences for patients of being placed under the scheme	Rate of use
• serious mental disorder (of either a 'continuous' or an 'intermittent' nature) • serious dangers to the health or safety of the patient, or of others, or the patient's seriously diminished capacity for self-care • the availability of appropriate outpatient care and social support.	Under the civil route of entry, a CommTO may be made: • by a District Court Judge, after a hearing; or • by a clinician, who may switch a patient to a CommTO from an involuntary Inpatient Order, previously made by a Judge. If the order is renewed again (after a year), it becomes indefinite in duration.	The subsequent procedures for review of involuntary outpatient status include: • mandatory clinical reviews, conducted at specified intervals by the Responsible Clinician and reported to the regional administrator • mandatory reviews conducted by the District Court during the first year of the CommTO • elective reviews conducted by a multi-disciplinary mental health review tribunal, on the application of the patient or other persons.	The precise conditions of the CommTO will be set by the responsible clinical team. The patient will usually be required to: • permit visits to their residence by members of the team (often weekly) • attend outpatient appointments as required (often a monthly appointment with a psychiatrist) • take medication as prescribed • remain at a specified kind of residence (e.g., a group home) • not travel beyond certain boundaries without permission • avoid substance misuse.	The main consequences of the order are to require the patient to accept treatment as directed by their Responsible Clinician and to accept visits at their residence from designated health professionals.	Figures provided to me informally by the NZ Ministry of Health suggest that roughly 1,700 people were on a CommTO on any day in NZ in 2003 (or were in the similar position of being "on leave", for up to six months, from involuntary inpatient status, an option that still exists in parallel with the CommTO scheme). NZ's population was about four million in 2003. So roughly one person in 2,350 was on a CommTO in NZ at that time.

Source: Dawson, J. (2005), *Community Treatment Orders: International Comparisons*. New Zealand: Otago University Print

3.1.1.2 New Zealand literature

A survey of New Zealand psychiatrists' clinical experience with the Mental Health (Compulsory Assessment and Treatment) Act of 1992 (Currier, G.W. 1997) found that it is perceived as time-consuming and cumbersome to administer. However, compulsory treatment orders were thought to facilitate community treatment.

A review of the ethical issues arising out of compulsory treatment in New Zealand and Australia (McIvor, R. 1998) concluded that "if the continued use of CTO is to be justified, both clinically and from the civil liberties perspective, controlled research needs to be carried out to identify whether CTOs are more effective than comprehensive assertive community outreach programs in reducing relapse rates and hospitalization, and increasing compliance."

Dawson, J. (2001) in a survey and chart review found that the great majority of New Zealand psychiatrists support community treatment orders as an option. While recognizing the potential for harming therapeutic relationships, they felt that community treatment orders are used properly in most cases, can enhance patients' priority for care, provide a structure for treatment, support continuing contact and produce a period of stability for patients during which other therapeutic changes can occur. (Romans, S. 2004) reports similar findings.

In an interview study of a small number of Maori on community treatment orders (Gibbs, A. 2004) the authors reported conflicts experienced in reconciling traditional beliefs with the medical model of mental illness but improved perceived well-being and social relationships.

Dawson, J. (2003) advances the view that New Zealand has avoided some of the difficulties of implementation in other jurisdictions where statutes suffer from being overly bureaucratic or unenforceable.

3.1.2 Australia

3.1.2.1 Victoria, Australia legislation

Criteria for a person's cover by the scheme	**Structure for its administration**	**Procedures to be followed**	**Allocation of powers and responsibilities under it**	**Consequences for patients of being placed under the scheme**	**Rate of use**
In combination, the focus of these criteria is upon: • mental illness on the part of the patient, indicated by a medical condition characterized by a significant disturbance of thought, mood, perception or memory • the prospect of relapse occurring in their illness, including its likelihood, and potential severity, and the consequences for the patient's health or safety • the need for involuntary treatment for the protection of other people • the need for immediate treatment to proceed, on an involuntary basis • refusal of treatment by the patient *or* their inability to give consent • the inadequacy of less restrictive alternatives • the availability of suitable outpatient care.	The responsibilities for patients under CommTOs are shared between: • senior psychiatrists, who exercise many key legal powers • supervising medical practitioners, who are usually psychiatrists-in-training and make many of the day-to-day clinical decisions • case managers, who are often social workers, nurses, or other non-medical members of a community team, who coordinate the patient's care. The senior psychiatrists have the major responsibilities for initiating and extending CommTOs, although the order's continuation is then reviewed by the board.	The procedures under which CommTOs are made and renewed emphasize: • the need for full consultation between clinicians and patients • the need for consultation with patients' families and carers, although usually with the consent of the patient • the use of interpreters • provision of plain-language explanations • provision of rights advice to patients • consultation between the different clinicians involved • regular review by clinicians of the patient's condition • the duty to terminate the order if its criteria no longer apply.	The CommTO may be revoked, and the patient recalled to hospital, if: • they continue to meet the criteria for involuntary treatment as a whole; and • their outpatient treatment is considered no longer viable; *or* • they have not complied with the order and certain risks to health or safety are posed. Comprehensive powers are provided to activate this recall process (ss 9A and 9B): • recall may be authorized by telephone • a designated range of health professionals, and the Police, may assist • entry both on to and into private property is authorized • the patient may be transported to a mental heath facility • in specified circumstances, reasonable force, restraint and sedation may be used.	*The consequences for the patient* The principal obligations imposed on the patient are: • to comply with the treatment listed in the plan • to maintain contact with the mental health service • to be available for regular assessment by clinicians.	A figure of this kind, provided in the Victorian Discussion Paper, says that roughly 2,700 people were on a CommTO in the state in 2003 (Mental Health Branch, 2003). As the Victorian population was roughly five million at that time, this means roughly one person in 1,850 was on a CommTO.

Source: Dawson, J. (2005). *Community Treatment Orders: International Comparisons*. New Zealand: Otago University Print

3.1.2.2 New South Wales, Australia legislation

Criteria for a person's cover by the scheme	Structure for its administration	Procedures to be followed	Allocation of powers and responsibilities under it	Consequences for patients of being placed under the scheme	Rate of use
The criteria for involuntary treatment focus on: • the presence of "mental illness", illustrated by seriously impaired mental functioning and listed psychiatric symptoms • the necessity for involuntary treatment to proceed, in order to protect that person or others from serious harm. In deciding whether these criteria apply, the person's "continuing condition", and the likelihood of its deterioration without treatment, may both be taken into account (s 9(2); *Harvey v Mental Health Review Tribunal* (1994) 33 NSWLR 351). Six further rules then apply to the use of CommTOs. These focus on (s 133): • the role of the order as a less restrictive alternative to hospital care • the existence of "an appropriate treatment plan" that can be implemented • evidence of previous refusal by the patient of appropriate treatment • their subsequent "relapse into an active phase of mental illness" • their deterioration leading to involuntary admission to hospital • effective treatment of their illness on such prior admissions.	Both Magistrates and the Tribunal may place patients on CommTOs in NSW. The order is to be made, in both cases, on the basis of a plan for the patient's treatment advanced by the responsible clinicians. Prior to 1 October 1997, the maximum life of a CommTO was three months. It was then extended to six months. Most orders are made for this maximum term. A CommTO may be renewed any number of times, and most are renewed at least once	The NSW Tribunal has a wide-ranging jurisdiction over the position of both forensic and civil patients. It has full-time leadership and about 100 part-time members. When reviewing individual cases, it sits in multi-disciplinary panels, chaired by a lawyer. The act states that its proceedings are to be "informal" and are not governed by strict rules of evidence: s 267. Very few CommTO patients appearing before the Tribunal are legally represented. Its workload is increasingly heavy and a cause of concern to its members. It conducted around 8600 hearings under the *Mental Health Act* in 2003. Roughly half of them concerned CommTOs.	The patient will usually be required: • to take medication as prescribed • to undergo associated medical tests • to accept reasonable supervision of their treatment, including clear arrangements to ensure medication compliance • to attend appointments for regular review by clinicians. For a CommTO patient to be recalled to hospital, it must be determined that (s 137): • they have either "refused" to comply with the order, or have 'failed to comply' • the agency responsible has taken "all reasonable steps to implement" the order • there is a "significant risk of deterioration in the mental or physical condition" of the patient.	• the patient "must comply with the order" (including the requirements of their treatment plan): s 145 • the staff of the responsible health care agency "may take all reasonable steps to have medication administered, and to provide services" in accordance with the order's terms: s 146(1) • medication may be administered to the patient in a community setting without their consent "if it is administered without the use of more force than would be required ... if the person had consented": s 146(2) • the staff may, without consent, 'enter the land' at the patient's residence, "but not the dwelling", in order to administer treatment: s 146(3). On the other hand, no specific statutory power is provided to direct where the patient shall live, even though a "residence requirement" is sometimes included in the patient's treatment plan.	Based on all these kinds of figures, concerning the numbers of CommTOs made, and the numbers of hearings about CommTOs before the Tribunal, and the figures provided by community agencies, it is possible to make a rough estimate of the number of patients on CommTOs in NSW in 2003. Somewhere between 2,000 and 3,000 people would have been on a CommTO, for a total population of roughly 6.6 million. If we adopt the median figure of 2,500, that would be one person in 2,640 on a CommTO in NSW in 2003.

Source: Dawson, J. (2005). *Community Treatment Orders: International Comparisons*. New Zealand: Otago University Print

3.1.2.3 Australian literature

The Office of the Chief Psychiatrist of the Ministry of Health of Western Australia (Rolfe, Tim: 2001) conducted a review of CTOs the central element of which was a survey of physicians. The article also includes an excellent overview of the international issues relating to compulsory community treatment. The general consensus was that for particular patients who require particular mental health services and who live in particular places, the CTO is a viable option for maintaining people with a mental illness living in the community.

(Kisely, S.R. 2004) examined whether compulsory community treatment for psychiatric patients reduces hospital admission rates. Using a case control design they examined 265 CTO cases in Western Australia and found that CTOs alone do not reduce admissions.

(Ozgul, S. 1997) in *A pilot study of the utilization and outcome of community orders: client, carer, case manager and Mental Health Review Tribunal perspective* point out the lack of research on CTOs in Australia. While finding a positive effect of CTOs in terms of compliance and hospital readmission, they caution that more rigorous research is required. Contrasting results also in Western Australia was reported by Preston, N.J. (2002). The study examined inpatient admissions, bed days, and outpatient contacts one year after subjects were placed on a community treatment order and compared them with a set of matched controls. No reduction in the use of health services among the 228 CTO clients studied was found.

Somewhat contrasting results were found by Vaughan, K. (2000) who also used a case control design to study CTO clients in New South Wales looking at readmission rates. While they identified some problems with the comparability of the control group, they found that the level of services in the 3 months following discharge were comparable for patients on CTOs and the comparison group. They identified the use of depot medication as a key factor.

According to Xiao, J. (2004), Western Australia has one of the highest published rates of CTO utilization in the world. Therefore, they examined the characteristics of patients being placed on CTOs. They concluded that CTOs were being used on patients of similar characteristics to other jurisdictions. They recommend further research to establish the relative contribution of patient characteristics, legislation and service setting toward the use and outcome of compulsory community treatment.

3.1.3 Scotland

3.1.3.1 Mental Health (Care and Treatment) (Scotland) Act 2003

Criteria for a person's cover by the scheme	Structure for its administration	Procedures to be followed	Allocation of powers and responsibilities under it	Consequences for patients of being placed under the scheme	Rate of use
• the patient has a "mental disorder" • medical treatment is available that would be likely to prevent that disorder worsening, or would be likely to alleviate its symptoms or effects • the patient's ability to make decisions about their treatment is "significantly impaired" • there would be a "significant risk" to the patient or others if treatment were not provided • the making of the CommTO is "necessary".	The central roles in the administration of the Scottish legislation will be played by: • Mental Health Officers (MHOs) • Responsible Medical Officers (RMOs) • the Mental Health Tribunal for Scotland (the Tribunal).	The plan may specify the duty of the patient: • to receive treatment outside hospital, including depot medication • to reside in a specified place, or in a specified form of supported accommodation • to afford access to health professionals, for the purposes of supervision or treatment • to obtain permission to change their place of residence.	Detailed provisions concerning "breach" of the requirements of the outpatient Treatment Plan are provided in the act (Part 7, Chapter 5). If the patient does not attend for treatment, they may be taken to hospital, and detained there for up to six hours, and treated without consent if that is authorized by their plan. If nonconsensual treatment is not authorized by their plan, the patient may still be taken to hospital and "be detained there for so long as is necessary to determine whether the patient is capable of consenting": s 112(4)(b). Alternatively, if the patient does not comply with some *other* term of their order, such as a residence requirement, they may be taken to hospital and detained there for up to 72 hours. Beforehand, all reasonable efforts must be made to ensure the patient's compliance, and it must be "reasonably likely that there would be a significant deterioration" in their mental health if they do not comply: s 113(2). The patient could then be detained in hospital for a further 28 days, if necessary, and so on.	The plan may specify the duty of the patient: • to receive treatment outside hospital, including depot medication • to reside in a specified place, or in a specified form of supported accommodation • to afford access to health professionals, for the purposes of supervision or treatment • to obtain permission to change their place of residence.	Not applicable; the act comes into force in October 2005.

Source: Dawson, J. (2005). *Community Treatment Orders: International Comparisons*. New Zealand: Otago University Print

3.1.4 England and Wales

3.1.4.1 Draft Mental Health Bill 2004

Criteria for a person's cover by the scheme	Structure for its administration	Procedures to be followed	Allocation of powers and responsibilities under it	Consequences for patients of being placed under the scheme	Rate of use
These initial criteria (called "the relevant conditions" in the Bill: clause 9) require that: • the patient suffers from a "mental disorder" • this is of such a nature or degree that its medical treatment is necessary • appropriate treatment would be available • the treatment is necessary to protect the patient from suicide or serious self-harm, or from serious neglect of their health or safety, or is necessary to protect others • there is no other lawful way to provide the treatment.	Those who would be primarily responsible for the management and review of patients under the act – their "clinical supervisors" and a Mental Health Tribunal – are granted reasonably flexible powers to determine where such patients would reside and where their treatment would take place. The patient could be shifted swiftly between resident and non-resident care. Even their initial assessment could take place outside hospital, and outpatient treatment could continue indefinitely, provided the necessity for it was regularly reviewed in accordance with the procedures established by law.	The Bill requires a Care Plan to be prepared for each involuntary patient (cl 31-32). This would state in general terms the form of mental disorder for which treatment would be authorized, and the treatment to be provided. Consultation with the patient and others is required in formulating the Plan, but the ultimate authority over treatment decisions lies with the clinical supervisor. In relation to some special forms of treatment, like ECT and psychosurgery, there would be a further, independent element in the approval process, involving the Tribunal.	The Bill specifically states that a non-resident patient may be required to attend for treatment at a specified place that is *not* a hospital (e.g., at a clinic). It also provides that the patient "may be taken into custody and conveyed to the relevant hospital or place" by the responsible clinicians (cl 80). But the Bill is equally specific that treatment without consent *cannot* be provided at such a clinic or "place". It can *only* occur in a "hospital" (cl 198), as that term is defined by law (cl 2). These powers appear virtually indistinguishable from those exercisable over patients under the current supervised discharge scheme. The Bill appears to go somewhat further, however, in the powers it provides to control where a non-resident patient shall live. Their precise place of residence may be specified. If they depart from it contrary to conditions imposed by their clinical supervisor, they are deemed to be "absent without leave". They may then be taken into custody by health professionals or the Police, and may be returned to that residence, or be taken to a clinic or hospital (cl 81).		Not Applicable

Source: Dawson, J. (2005). *Community Treatment Orders: International Comparisons*. New Zealand: Otago University Print

3.1.5 Israel

Legislation permitting compulsory community treatment was enacted in Israel in 1991 with the *Treatment of Mental Patients Law of 1991*. (Lefkovitch, Y. 1993) (Silfen, P. 1995) (Durst, R. 1999) According to Durst "...a district psychiatrist is entitled, after a psychiatric examination, to order compulsory ambulatory treatment. The patient is assigned to a designated clinic, under specified conditions, for a period not exceeding six months, with the possibility of six-month extensions." Prior to the 1991 legislation compulsory treatment was only permitted in a hospital setting. The criteria for compulsory community treatment are identical to those while in hospital. The orders are for up to six months and the remedy for non-compliance is compulsory hospitalization.

Lefkovitch, Y. (1993) in *Involuntary outpatient commitment: ethics and problems* compares and contrasts the Israeli system with that of the United States highlighting the differences with respect to eligibility and enforcement.

Durst, R. (1999) conducted a one-year follow-up of 326 orders made in the first four years of the program's implementation. There was not a control group. "Success was defined as continuous treatment for the entire six-month period of compulsory ambulatory treatment, or as voluntary hospitalization during or after the compulsory treatment period. The compulsory ambulatory treatment order was found to be efficacious in 43.3 percent of the cases; in 32.5 percent it did not succeed in preventing compulsory hospitalization, and in the remaining cases (22.1 percent), success was partial."

Ajzenstadt, M. (2001) finds that in some parts of the country psychiatrists rarely impose compulsory ambulatory treatment due to the lack of community facilities. Some psychiatrists report a reluctance to carry out what they regard as a policing function.

Greenberg, D. (2005) provides an interesting view of the Israeli program from the perspective of one community mental health centre in Israel. A group of 27 patients referred for involuntary community treatment were followed for a period of three to five years. Comparisons were done with patients' experience before and after being placed on involuntary community treatment and significant reduction in hospitalizations was found. "Thirteen patients were interviewed at the termination of the commitment, and nearly all perceived the commitment in negative terms, although eight did not think it had a negative effect on their relationship with the psychiatrist and six thought their opinions were respected. Six of the psychiatrists considered they were not giving optimum treatment. Despite the presence of the commitment, psychiatrists were often sensitive to patients' wishes and the involuntary aspect of the care was often not pursued. While half of the sample were lost to community care, half remained for several years. The study reflects the delicate nature of involuntary care in the community, so that in practice it is often not involuntary, not for outpatients and not a commitment."

3.1.6 United States of America

More than half of the States have legislation permitting some form of involuntary community treatment according to *A national survey of the use of outpatient commitment* (Torrey, E.F. 1995). The authors conducted a national survey of the use of outpatient commitment and concluded: "Thirty-five states and the District of Columbia have laws permitting outpatient commitment. Georgia, Hawaii, and North Carolina use different criteria for outpatient commitment than for inpatient commitment. In only 12 states and the District of Columbia was use of outpatient commitment rated as very common or common. Reasons for not using it include concerns about civil liberties, liability, and fiscal burden as well as lack of information and interest, the failure of some states to set enforceable consequences for non-compliance, and criteria that are too restrictive. Some states use alternative formal or informal mechanisms to encourage treatment compliance; conditional release is widely used in New Hampshire and conservatorship-guardianship in California. Within many states the availability of outpatient commitment varies considerably by locale."

In the RAND report, discussed at length below, the authors examine the experience of eight states in detail. (Ridgely, M. Susan 2001) The states are Michigan, New York, North Carolina, Ohio, Oregon, Texas, Washington and Wisconsin. They summarize their findings as follows:

- Each of the states (most by statute, one by judicial interpretation) have a "grave disability" provision. This reflects the growing popularity of such provisions nationally
- Most states have provisions permitting outpatient treatment as part of the commitment process. While the processes and substantive criteria used by the states vary, the traditional model of civil commitment as a vehicle primarily for inpatient treatment has eroded

- Many of these states have different standards for outpatient and inpatient commitment. While the procedural standards tend to be the same (except in North Carolina, where counsel is not required in outpatient commitment proceedings) the length of commitment as well as the substantive standards may vary between inpatient and outpatient commitment
- Some states permit outpatient treatment as part of commitment only on a showing that resources are available to provide treatment
- Many of these states explicitly permit the use of the person's prior treatment or behavioural history in determining whether a person meets commitment standards. This represents a shift from laws that for the last two decades have tended to focus on behaviour contemporaneous with the period in which the commitment hearing is held
- In general, medication compliance is handled separately from the civil commitment hearing (Wisconsin is an exception), and states do not use extended hospitalization as a consequence for non-adherence to treatment.

In an overview of state outpatient civil committal Reed, D.B. (2000) characterizes the legislation as including:
- Right to a hearing;
- Timely notice of the hearing;
- Representation by counsel;
- A time-limited commitment order (varying by state from 45 days to one year) with rights to review and hearing if extensions are requested;
- Right to appeal the order; and
- Court review after a specified period of time to determine whether commitment criteria continue to be met.

Reed goes on to observe that:
- Most states incorporate a least restrictive alternative requirement as to the type of treatment and commitment employed
- The requirement of a treatment plan that the court makes part of its commitment order constitutes a feature of many mandatory outpatient treatment laws
- Statutes may also direct that the actual treatment provider be specified by the court order, and that they agree to accept the patient and provide the ordered treatment
- Enforcement mechanisms, should the individual not comply with the ordered treatment, vary considerably by state, as well as by type of order, i.e., conditional release, initial commitment, etc. Mechanisms that are specified in state statutes include one or more of the following: that the responsible service provider report non-compliance to the court, and/or file a petition for inpatient commitment; that service providers notify law enforcement; that law enforcement officers transport the noncompliant individual to a designated outpatient facility
- Actual utilization of outpatient commitment varies widely from state to state, but in the majority of states these procedures are infrequently used. According to the Health Policy Tracking Service, 23 of 38 states surveyed and DC rarely or very rarely order outpatient commitment, while 13 order it commonly or very commonly and three order it occasionally.

3.2 Canada

Canadian compulsory community treatment laws: recent reforms (Gray, J.E. 2005) provides an excellent overview of the contemporary Canadian legal environment for compulsory community treatment.

Various forms of conditional leave are available in British Columbia, Alberta, Manitoba, New Brunswick, Yukon, Prince Edward Island and Ontario. Under conditional leave the patient must continue to meet the committal criteria for involuntary hospitalization but is permitted to live in the community provided that he or she continues to meet the conditions set out in the leave. There are variations among the jurisdictions as to pre-conditions, renewal and consent.

	Pre-conditions	Renewal	Consent
British Columbia	Services to meet the condition must be available. Must continue to meet "danger" or "deterioration" criteria	Renewable	Hospital or physician authorizes leave
Alberta	Must continue to meet "danger" criteria	Renewable	Hospital or physician authorizes leave
Manitoba	Prohibited on first admission. Must continue to meet "danger" or "deterioration" criteria	Renewable	Patient or substitute consent required
New Brunswick	Must continue to meet "danger" or "deterioration" criteria	Renewable	Hospital or physician authorizes leave
Yukon	Must continue to meet "danger" criteria	Renewable	Patient or substitute consent required
Prince Edward Island	Must continue to meet "danger" or "deterioration" criteria	Renewals not allowed (10 days only)	Patient or substitute consent required
Ontario	Must continue to meet "danger" or "deterioration" criteria	Renewals not allowed (three months only)[1]	Hospital authorizes leave

Source: Adapted from Gray, J. E., and O'Reilly, R. L. (2005). *Canadian compulsory community treatment laws: recent reforms. International Journal of Law and Psychiatry*, 28(1), 13-22.

In Quebec a judge's authorization for treatment may extend after hospital discharge.

Data on the extent to which conditional hospital leaves are used in the seven jurisdictions is not provided in the article.

For a better understanding of the broader mental legislative context in Canadian jurisdictions refer to *Clinically significant differences among Canadian mental health acts* (Gray, J.E. 2001).

The conditions under Saskatchewan's legislation for completion of a community treatment order include:

1. A person must suffer from a mental disorder for which he or she is in need of treatment or care that can be provided in the community.
2. In the previous two years the person must have
   - spent at least 60 days as an involuntary inpatient in a psychiatric facility, or
   - been an involuntary inpatient in a psychiatric facility on three or more separate occasions, or
   - previously been the subject of a community treatment order.
3. There must be a likelihood that if the person were not to receive treatment while residing in the community, he or she would likely cause harm to self or others or suffer substantial mental or physical deterioration as a result of the mental disorder.
4. The services the person requires in order to reside in the community must be available in the community.
5. The person is unable to understand and to make an informed decision regarding his or her need for treatment, care, or supervision as a result of the mental disorder.
6. The person must be capable of complying with the requirement for treatment and supervision contained in the CTO. (O'Reilly, R.L. 2000)

Unlike Ontario, examination by two physicians is required in Saskatchewan. Also, consent is not required from either the patient or the substitute decision-maker. The physician following a "best interest" criteria makes the

[1] Contrary to Gray's findings it is our view that they are renewable in Ontario.

decision. (Gray, J.E. 2005) The use of community treatment orders has been modest with rates of 14 orders per year for a population of 1 million. (O'Reilly, R.L. 2000)

The debate in Canada about the balance between access to care and individual rights and liberties is not a new one. For example, Roberts, C.A. (1989) expresses the concern that, "In recent decades these two trends have contributed to the present situation in which it is difficult to recruit competent, well-motivated clinical staff for our more isolated mental hospitals and there is increasing emphasis on legalistic aspects of individual civil rights, compulsory treatment and related factors with little attention to the patient's entitlement to and need for adequate treatment."

In January of 1990 – ten years before the CTO legislation was changed – the Ontario Ministry of Health issued *Discussion Paper Towards Community Mental Health Services Legislation* and invited input to the process of legislative reform. Boudreau, F. (1993) in *Compulsory community treatment? I. Ontario stakeholders' responses to "helping those who won't help themselves"* does a content analysis of the 224 responses. They describe the analysis as a first step in considering compulsory community treatment by looking at stakeholder responses. Boudreau, F. (1993) in *Compulsory community treatment? II. The collision of views and complexities involved: is it "the best possible alternative"?* explores what is termed the "highly controversial issue concerning the compulsory treatment of allegedly mentally disordered persons within the community." Practical implementation issues are raised. They conclude that, "what today's mental health system unequivocally requires is real commitment on the part of government to make a greater political, organizational, and financial commitment to effective partnership models and to a balanced mental health system."

Cashman, F. (1997) also examined the issues associated with implementation of compulsory community treatment.

O'Reilly, R.L. (2000) reviewed the pattern of use of mandatory treatment in Saskatchewan. Saskatchewan was the first province to implement a CTO program in Canada. While the psychiatrists surveyed were only treating 14 clients in the program, they indicate general satisfaction. The authors concluded from the survey that, "While CTOs are used for only a small number of patients in Saskatchewan, they are a clinically useful tool for dealing with a group of otherwise difficult-to-treat patients."

Everett, B. (2001) wrote *Community treatment orders: ethical practice in an era of magical thinking* in the wake of the introduction of the CTO legislation in Ontario. Everett examined the issues and concerns that were expressed in the process leading up to the legislation. He identifies the desirability of a therapeutic alliance with the patient based on being a voluntary and an equal partner. He cautions against what he terms "magical thinking" and proposes a definition of coercion that recognizes both overt and covert forms.

Gray, J.E. (2001) in *Clinically significant differences among Canadian mental health acts* conducted the first of two overviews of Canadian mental health legislation. While this article is broader in context than CTOs, it does review conditional leave and community treatment order provisions. They took the statement of principles for mental health legislation endorsed by the Canadian Psychiatric Association as a point of departure. They found clinically significant differences among the legislation and concluded that: "Provisions that prevent patients receiving appropriate clinical care can be found in some Canadian mental health acts. Alternate provisions that support appropriate clinical care, that respect the human rights and personal dignity of patients, and that are consistent with the Canadian Charter of Rights and Freedoms can be found in the legislation of other jurisdictions."

Szigeti, A. (2001), in *Ontario's Community Treatment Orders: how did we get there and where do we go now? An advocate's perspective*, characterizes the CTO legislation as the single most hotly contested event in the history of mental health legislation in the province. She considers that the public link made in the media between the legislation and dangerousness only serves to further stigmatize the mentally ill. Comparisons are made between the Ontario and US legislation and she outlines the evolution of mental health legislation in Ontario leading up to the debates over the CTO legislation. Ethical, clinical and legal considerations are presented emphasizing problems of statutory interpretation and consistency with the Charter of Rights and Freedoms. Writing at a time before any CTOs were issued in Ontario, she concludes, "the fear remains that the community treatment order law lights the short and bumpy road to serious injustice for persons with mental health problems."

There have been a number of books relating to mental health law in Canada written in recent years:

- Bloom, Hy (1996) *A Practical guide to mental health, capacity and consent law of Ontario* (somewhat dated as it precedes the changes in Ontario's community treatment legislation)
- Gray, John E. (2000) *Canadian mental health law and policy*
- Ministry of Health and Long-Term Care (2001) *Rights and responsibilities: mental health and the law (a practical guide to consent and capacity law in Ontario)*

- Caulfield, Timothy A. (2002) *Health care reform & the law in Canada: meeting the challenge.*
- Hiltz, D'Arcy (2005) *A guide to consent and capacity law in Ontario* (an excellent practical source for practitioners and lawyers on the workings of the relevant legislation including CTOs).

The Canadian Psychiatric Association (2003) *CPA Position Paper: Mandatory Outpatient Treatment* is an influential document that sets out the Association's belief that "mandatory outpatient treatment has benefits in certain clearly defined situations, and the CPA supports the use of mandatory outpatient treatment if specific legal rights and safeguards are in place." This paper considers ethical and practical issues with compulsory community treatment.

Trueman, S. (2003) in *Community treatment orders and Nova Scotia – the least restrictive alternative?* is critical of Canadian legislation, maintaining that it is illogical and inconsistent but concludes that, "Patience and the support of a new and better system that puts voluntariness and the mental health consumer in the centre of decision-making is the most promising way to effective mental health care."

In September 2004, the *Canadian Journal of Psychiatry* included an editorial and feature articles on CTOs. The editorial entitled *Community treatment orders: an uncertain step* (Chaimowitz, G.A. 2004) expresses some reservations, concluding, "The evidence remains unclear, and the arguments on both sides are not without merit, but uncertainty sits uncomfortably in modern medical practice. Both sides speak to the rights of patients, and both seek the moral high ground. Thoughtful and intelligent people have weighed in, and we have initiated a genuine debate in psychiatry. CTOs may very well be an expression of both the best and the worst in current psychiatric practice. At best, we are looking at paternalism—benevolent coercion respectful of autonomy and liberty. At worst, we ignore the concerns of fairness and justice. Just exactly how do we balance autonomy and paternalism?"

The first companion article (O'Reilly, R. 2004) *Why are community treatment orders controversial?* outlines the major areas of contention over CTOs including: freedom of choice, use of coercive force, effectiveness, impact on therapeutic relationship, less intrusive alternatives, capacity, the focus on violence, duration of CTOs, resource implications and the difficulty of ensuring rights in a community setting. The article concludes that, "It is difficult to conceive how this [the transition to community treatment] can be successfully achieved without transferring to the community some components of the legal authority that has been necessary to provide adequate care and treatment in hospitals."

In the second article from the same edition, the North Carolina researcher Swartz, M.S. (2004) in *Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: what's in the data?* reviews the literature and concludes: "On balance, empirical studies support the view that OPC[1] is effective under certain conditions, although some of the evidence has been contested and the policy remains controversial."

In what we hope will be a growing body of published Ontario research, (O'Brien, A.M. 2005) *Community treatment orders: profile of a Canadian experience*, reports on an Ottawa based study which compared clients before and after being placed on a CTO. They looked at hospital use rates, use of support services and housing outcomes. They conclude that, "CTOs are effective tools for allowing patients to live in the least restrictive setting possible while they receive diverse services. They also effectively reduce rates and lengths of readmission to hospital." However they caution that, "Future studies need to systematically evaluate the efficacy of all aspects of the CTO plan to determine the critical elements of their success from the perspective of both patients and health care professionals."

3.3 Clinical Trial Evidence

In the world of health services research, the randomized controlled trial (RCT) is viewed as the "gold standard" – the standard against which other research is measured. Randomization endeavors to ensure that every member of a population has an equal chance to be included in the study's sample without regard for potential biases. Individuals are assigned to an experimental group, which receive the treatment, and a control group, which receives either a placebo or the standard treatment. An RCT is a true experiment in which – if done properly – the cause and effect relationship between treatment and outcome can be determined by following the experimental and control groups outcomes prospectively. Other forms of clinical trials such as the cohort study and the case-controlled trial are still useful but provide less compelling evidence than the randomized controlled trial.

Because of the implications for civil liberties, it is important that there be solid clinical evidence for the efficacy of involuntary community treatment. (O'Reilly, R. 2001) There are usually reasons why randomization is not easy.

[1] Outpatient commitment.

There are also ethical and legal problems. (Dawson, J. 2002) Family members and clinicians who become part of the trial should be part of the consent process.

There have been two comprehensive reviews of the research evidence relating to the effectiveness of involuntary outpatient treatment, one by RAND and another just published by The Cochrane Collaboration.

The RAND Corporation is a non-profit institution in the United States that is dedicated to improving policy and decision-making through research and analysis. RAND research is widely considered to be characterized by objectivity, nonpartisanship scientific rigor, and an interdisciplinary approach, across a broad range of subjects.

The Cochrane Collaboration is an international non-profit and independent organization, dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions.

3.3.1 RAND Review

In 2001 RAND published *The Effectiveness of Involuntary Outpatient Treatment:* Empirical Evidence and the Experience of Eight States (Ridgely, M. Susan 2001), which was the first comprehensive evidence-based review of the effectiveness of involuntary outpatient treatment. An evidence-based review is a scientific investigation that critically analyzes studies rather than simply reporting their findings. As discussed earlier, the team reviewed statutory and case law on involuntary treatment in eight U.S. states, chosen because they have involuntary outpatient treatment systems, some of which had been rigorously studied.

They were asked by the Senate of California as a part of consideration of new legislation:

- To identify and synthesize the existing empirical evidence on the effectiveness of involuntary outpatient treatment and its alternatives;
- To gather and analyze information on the experience of a select group of states where involuntary outpatient treatment is currently practiced; and
- To assess the potential impact of such legislation on people with severe mental illness in California.

RAND identified what they termed two generations of effectiveness research. "The first generation of studies mostly found limited positive results from involuntary outpatient treatment; however, these studies were plagued by significant methodological limitations. These limitations reduce the confidence we can place in their findings. In addition, this body of research did not specify for whom, how, or under what circumstances court-ordered outpatient treatment may work."

RAND identified only two second-generation studies. These were randomized clinical trials of involuntary outpatient treatment conducted in New York City and in North Carolina. The results of the two studies produced conflicting conclusions.

> *Assessing the New York City involuntary outpatient commitment pilot program* (Steadman, H.J. 2001)
> A total of 142 participants were randomly assigned; 78 received court-ordered treatment, which included enhanced services, and 64 received the enhanced-service package only. Outcome measures included rehospitalization, arrest, quality of life, symptomatology, treatment non-compliance, and perceived level of coercion. On all major outcome measures, no statistically significant differences were found between the two groups. The researchers caution that all results must be qualified by the fact that no pick-up order procedures for noncompliant subjects in the court-ordered group were implemented during the study, which compromised the differences between the conditions for the two groups, and that persons with a history of violence were excluded from the program.

RAND concludes: "The investigators in New York found no statistically significant differences in rates of rehospitalization, arrests, quality of life, psychiatric symptoms, homelessness or other outcomes between the involuntary outpatient treatment group and those who received intensive services but without a commitment order. However, a number of limitations in the New York study (e.g., small sample size, non-equivalent comparison groups, lack of enforcement of court orders), may have affected the findings and make it difficult to draw definitive conclusions."

> *A randomized controlled trial of outpatient commitment in North Carolina* (Swartz, M.S. 2001)
> A total of 331 involuntarily hospitalized patients awaiting discharge under outpatient commitment were

randomly assigned to be released or to undergo outpatient commitment. Each received case management services and outpatient treatment. Participants in both groups were monitored for one year. In most bivariate analyses, outcomes for the outpatient commitment group and the control group did not differ significantly when the duration of outpatient commitment was not taken into account. However, patients who underwent sustained outpatient commitment and who received relatively intensive outpatient treatment had fewer hospital admissions and fewer days in the hospital, were more likely to adhere to community treatment, and were less likely to be violent or to be victimized. Extended outpatient commitment was also associated with fewer arrests of participants with a combined history of multiple rehospitalizations and previous arrests. The intervention was particularly effective among individuals with psychotic disorders. CONCLUSIONS: Outpatient commitment can improve treatment outcomes when the court order is sustained and combined with relatively intensive community treatment. A court order alone cannot substitute for effective treatment in improving outcomes.

RAND concludes: "In contrast to the New York study, the Duke study, which is the better of the two, suggests that a sustained outpatient commitment order (180+ days), *when combined with intensive mental health services*, may increase treatment adherence and reduce the risk of negative outcomes such as relapse, violent behavior, victimization, and arrest. According to the Duke investigators, the two most salient factors associated with reduced recidivism and improved outcomes among people with severe mental illness appear to be intensive mental health treatment and enhanced monitoring for a sustained period of time. In the Duke study, outcomes were only improved for those under court order who received intensive mental health services. *Whether court orders without intensive treatment have any effect is an unanswered question.*"

RAND had additional reservations about the study conditions

- The experimental group may have received more outpatient services and had them more consistently provided
- Enforcement was consistently applied in a way that might not be consistent with normal community practice
- The sample included only patients entering the study from hospital, not from the community directly
- Conclusions about effects from lengths of commit should be made with caution because commitment length was not randomized.

RAND concludes that: "In contrast to the paucity of studies on involuntary outpatient treatment, our review of the literature found clear evidence that alternative community-based mental health treatments can produce good outcomes for people with severe mental illness... The question left unanswered by the research to date is whether involuntary outpatient treatment and voluntary alternatives produce equally good outcomes... Involuntary outpatient treatment by definition includes a treatment intervention. As a result, there is no study that proves that a court order for outpatient treatment *in and of itself* has any independent effect on outcomes. No randomized clinical trials have examined the relative efficacy of involuntary outpatient treatment and assertive community treatment – the alternative with the best record of producing positive outcomes for people with severe mental illness. In addition, assertive community treatment may also employ high levels of monitoring and supervision, similar to the kinds of monitoring found in involuntary outpatient treatment but without the coercive element of a court order. We simply do not know whether such forms of supervision and monitoring are as effective."

3.3.2 The Cochrane Collaboration Review

Stephen Kisely of Dalhousie University led a team from The Cochrane Collaboration undertaking a systematic review and meta-analysis of the effectiveness of involuntary outpatient treatment from both randomized and non-randomized trials (Kisely, S. 2005). Fortunately the results of this systematic review are now available.
A systematic review is a comprehensive survey of a topic in which all of the primary studies of the highest level of evidence have been systematically identified, appraised and then summarized according to an explicit and reproducible methodology. A meta-analysis is a survey in which the results of all of the included studies are similar enough statistically that the results are combined and analyzed as if it was one study. In general a good systematic review or meta-analysis will be a better guide to practice than an individual article.

Cochrane identified only two randomized clinical trials – the same ones reviewed by RAND. Cochrane conducted a meta-analysis on the data from the New York and North Carolina studies. They used the following typology to analyze outcomes:

A. Health service outcomes
    1. Health service contact and utilization
        1.1 Admission to hospital
        1.2 Mean days spent in hospital per month
        1.3 Remaining in contact with psychiatric services – leaving the study early
B. Patient level outcomes
    2. Social functioning
        2.1 General
        2.2 Specific – imprisonment, police contact and arrests*
        2.3 Specific – employment
        2.4 Specific – accommodation status
    3. Mental state
        3.1 General
        3.2 Specific – psychopathology
    4. Quality of life
        4.1 General
        4.2 Self-esteem
    5. Satisfaction
        5.1 Number of needs for care
        5.2 Patient satisfaction
        5.3 Career satisfaction
        5.4 Perceived coercion

Cochrane found little evidence that compulsory community treatment was effective for any of the outcome measures indicated. "It appears that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. There is currently no evidence of cost effectiveness. People receiving compulsory community treatment were, however, less likely to be a victim of violent or non-violent crime. It is, nevertheless, difficult to conceive of another group in society that would be subject to measures that curtail the freedom of 85 people to avoid one admission to hospital or of 238 to avoid one arrest."

Cochrane concludes as follows:

1. ***For people with serious mental illnesses***
Patients and carers should question the rationale for compulsory community treatment and advocate more effective treatments.

2. ***For clinicians***
Clinicians and health service planners who wish to reduce hospital admissions should consider alternatives with stronger evidence for effectiveness such as Assertive Community Treatment.

3. ***For policy-makers***
Based on results from this review, there is no strong evidence to support the claims made for compulsory community treatment that make it so attractive for legislators. It does not appear to reduce health service use or improve patients' social functioning. It also does not significantly reduce perceived coercion. Lack of data made it impossible to assess its effect on costs, mental state and other aspects of patient/carer satisfaction.

Cochrane also expressed strong support for more research, noting with surprise that the only randomized trials relate to court ordered community treatment, even though community treatment orders are being so widely used in some jurisdictions.

3.4 Selected Topic from the Literature: Coercion

Coercion is a central theme in the literature from a variety of perspectives, most prominent of which are: protection of individual rights; potential for fracturing the patient/clinician relationship and the potential chilling effect coercion may have on individual's willingness to seek care.

The debate about the benefits of compulsory outpatient treatment versus the liabilities of coercion is not a new one to the literature and has a longer history in the context of mandatory inpatient treatment. For example,

Geller, J.L. (1986) in *Rights, wrongs, and the dilemma of coerced community treatment* writes that "the coercive nature of the treatment raises questions about the psychiatrist's violation of patients' rights and transgression of ethical standards as set against the potential for favorable outcomes for patients with histories of psychotically based dangerousness, poor compliance, and recidivism."

In *Involuntary hospitalization of the mentally ill as a moral issue*, Chodoff, P. (1984) discusses the conflict between medical model and civil liberties approaches to involuntary hospitalization for mental illness. His observations are also relevant to the debate about compulsory community treatment. He concludes that "the amassing and analysis of data will not resolve this conflict because the two sides view the problem from differing moral vantage points. Medical model adherents are influenced chiefly by utilitarian or consequentialist considerations, while the civil libertarians take more of a deontological or absolutist position. Opinions about such issues as hospitalization criteria of dangerousness versus medical necessity and the relative role of rights versus obligations and of autonomy versus paternalism can be seen largely to depend on such underlying value judgments." The article concludes that neither side has a monopoly on truth or right in the question of involuntary hospitalization.

In a cautionary article, *Opening Pandora's box: the practical and legal dangers of involuntary outpatient commitment* (Allen, M. 2001), the authors "review the therapeutic claims for outpatient commitment and take the position that there is insufficient evidence that it is effective. They offer arguments that outpatient commitment may not improve public safety and may not be more effective than voluntary services. The authors further point out that outpatient commitment may undermine the delivery of voluntary services and may drive consumers away from the mental health system."

Coercion in the community: issues for mature treatment systems (Diamond, R.J. 1995) provides an excellent overview of coercion from a clinical perspective. The author discusses coercion and paternalism in the context of community treatment, the range of coercive interventions available in the community, court-ordered treatment as the most extreme end of the continuum of intervention, and ways to decrease the need for coercion. "Coercion, however it is applied, interferes with autonomy, and can interfere with the sense of personal effectiveness that makes rehabilitation possible. Historically, mental health staff have assumed that they know what is best for their clients. Many clients will achieve a higher quality of life if helped to achieve their own goals, rather than being forced to follow paths laid down by a therapist or case manager."

In contrast, Brown, J.D. (2003) in *Is involuntary outpatient commitment a remedy for community mental health service failure?* concludes: "Involuntary outpatient commitment (IOC) statutes exist in response to disorganized community mental health service delivery and perceived treatment non-compliance. These statutes attempt to force psychiatric patients to comply with outpatient mental health services. Mental health service consumers, providers, and advocates have increasingly questioned the necessity and legality of IOC. Credible research indicates that IOC does not substantially benefit consumers and may increase mental health deterioration. IOC has proven difficult to implement, enforce, and successfully measure. Rather than resorting to expanding coercive measures, mental health systems and policymakers must ensure provision of voluntary and accessible mental health services. Furthermore, IOC cannot be legally or ethically justified even if hypothetical research supporting its alleged effectiveness exists."

In response to the enactment Ontario CTO legislation, *Community treatment orders: ethical practice in an era of magical thinking*, Everett, B. (2001) flags the potential for both overt and covert forms of coercion and recommends approaches to avoid coercion which are termed liberation tactics, proactive contracting, and procedural justice.

Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals (Swartz, M.S. 2003) reports on a survey of 85 mental health professionals and 104 individuals with schizophrenia spectrum conditions to assess their experience with and perceptions of involuntary treatment and other treatment mandates. "Reluctance to seek outpatient treatment associated with fear of coerced treatment (mandated treatment-related barriers to care) was significantly more likely in subjects with a lifetime history of involuntary hospitalization, criminal court mandates to seek treatment. However, experience with involuntary outpatient commitment was not associated with barriers to seeking treatment. These results suggest that mandated treatment may serve as a barrier to treatment, but that ongoing informal pressures to adhere to treatment may also be important barriers to treatment."

The perceived coerciveness of involuntary outpatient commitment: findings from an experimental study (Swartz, M.S. 2002) examines "self-reported coercion in subjects with severe mental illness who were randomly assigned in an experimental study to continue under, or be released from, involuntary outpatient commitment (OPC) subsequent to hospital discharge. After review of bivariate relationships, multivariable analyses demonstrated significantly higher levels of reported coercion among subjects who experienced longer periods of OPC; who were African American; who were single and not cohabiting; and who had ongoing substance abuse problems, poor insight into illness, and severe symptoms. They conclude that a consequence of OPC is increased perceptions of coercion in the treatment process, which is partially explained by the increased attention by case managers to non-compliance with treatment."

Contrasting results were obtained in *Assessing the New York City involuntary outpatient commitment pilot program* (Steadman, H.J. 2001). This randomized trial is discussed at greater length elsewhere. Among other outcomes, "perceptions of the degree of coercion were measured for both the experimental group, the members of which received court-ordered treatment, which included enhanced services, and the control group whose members received the enhanced-service package only. It found participants' perceptions of their quality of life and level of coercion were about the same."

In *Assessment of four stakeholder groups' preferences concerning outpatient commitment for persons with schizophrenia* (Swartz, M.S. 2003) the authors "compare views of outpatient commitment among four stakeholder groups: 1) persons in treatment for schizophrenia and related disorders, 2) family members of persons with these disorders, 3) clinicians treating persons with these disorders, and 4) members of the general public. With some exceptions, each group gave the highest preference to avoiding involuntary hospitalization, followed by avoiding interpersonal violence and maintaining good interpersonal relationships. No group gave appreciable importance to outpatient commitment, which suggests that avoiding its coerciveness is a lesser concern compared to other outcomes. The findings suggest that these stakeholders are willing to accept the coerciveness of outpatient commitment to gain improved outcomes for certain persons with schizophrenia and related disorders."

Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness (Swanson, J.W. 2003) reports on a study in which involuntarily hospitalized subjects, awaiting discharge under outpatient commitment, were randomly assigned to be released or continue under outpatient commitment in the community after hospital discharge, and were followed for one year. "Quality of life was measured at baseline and 12 months follow-up. The study concluded that involuntary outpatient commitment, when sustained over time, indirectly exerts a positive effect on subjective quality of life for persons with severe mental illness but that perceived coercion moderated the positive effect on quality of life."

In *A 'bittersweet pill to swallow': learning from mental health service users' responses to compulsory community care in England* (Canvin, K. 2002), the authors interviewed service users about their understanding of why mental health professionals placed them on the Supervised Discharge Orders and how their lives have been affected. They found that individual service users are capable of seemingly contradictory responses, simultaneously accepting and resisting the orders. "These responses are fatalism and resignation, dependency, ownership, bargaining, cooperation, resistance, and rejection." The study proposes a model for understanding how service users respond to compulsory community care where their options are legally constrained.

4.0 Data

4.1 Data from Established Sources

The data that provides information about individual CTO clients and their care is dispersed, fragmented and incomplete. It is collected by the MOHLTC through several different program areas and maintained in different databases. Other data on CTOs was available to us from the Psychiatric Patient Advocate Office (PPAO), from the Consent and Capacity Board (CCB), and from agencies that provide CTO-related services.

Where possible we linked data from different sources by using a client's initials, date of birth and gender to provide as comprehensive a view as possible of CTO-related activities. This approach maintained client anonymity (we do not know who clients are), while minimizing the likelihood of confusing the data for two or more individuals. Throughout this review the data has only been used on an aggregated basis.

Our objective was to analyze and summarize the data in a way that would provide information about:
- CTO clients and the services that they receive
- the geographic use of CTOs
- the provision of rights advice
- the disposition of applications to the CCB.

We also collected some data about patients who are receiving community care outside of a CTO. Similarly, we sought data/information on the use of leaves of absence from a psychiatric facility under section 27 of the *Mental Health Act*.

In addition to the foregoing, we placed a survey on the website that we opened for the project at **www.ctoproject.ca.** This survey allowed respondents to either complete it online or to submit a paper copy to the consultants. The website also included a format for submissions from agencies that deal with CTO clients.

A significant outcome of our review of the data is an assessment of what will be required to allow for a more rigorous future evaluation of the use of CTOs.

4.1.1 OHIP Data

Ontario has a public, single payer health insurance system. The single payer is known as the Ontario Health Insurance Plan (OHIP). Most psychiatric services are paid by OHIP on a fee-for-service basis. Some physicians, however, are compensated on a salary or contract basis. Still others receive part of their compensation from block fees. These fees are referred to as "sessional fees."

Fee-for-service physicians are required to submit data regarding CTO services to OHIP in two ways.

Physicians are required to keep a *Community Treatment Order (CTO) Report Log* and submit it to OHIP along with their claims submission. This is a monthly log for each CTO patient, for each of the three OHIP billing codes:
- K887 CTO Initiation – including completion of the CTO form and all preceding CTO services directly related to CTO initiation
- K888 CTO Supervision – including all associated CTO services except those related to initiation or renewal
- K889 CTO Renewal – including completion of the CTO form and all preceding CTO services directly related to the CTO.

The log provides data on the services provided, distinguishing between consultation/assessment, interviews, on-going therapy, community treatment plan (CTP) preparation, conferences/meetings, telephone advice, and forms.

Only a few physicians regularly or periodically submit these logs. This could be because submission of the log is not directly linked to payment by OHIP even though the log is meant to form the basis of the physician's billing to OHIP. Because of the incomplete nature of these submissions, OHIP staff have not developed a method to accumulate the data electronically. It should be noted that physicians who are not required to submit fee-for-service claims to OHIP, i.e., those on salary or those paid by sessional fee, are not required to complete and submit the CTO-related forms.

Then there is the actual claim that is submitted for services provided under OHIP billing codes K887, K888, and K889. These claims are paid at the rate of $65.55[4] per half-hour unit (or major part thereof), subject to rules about frequency, etc.

According to OHIP staff, "a single all-inclusive claim for CTO Initiation or CTO Renewal is submitted once per patient, per physician, per initiation or renewal, in any six-month period on an Independent Consideration[5] basis." In addition, "the CTO Report Log for each code must accompany each claim for OHIP services. The log must be submitted monthly for each fee code and one copy retained on the patient's permanent medical record. Each physician is required to complete a monthly CTO Report Log detailing the date and duration of insured activities associated with each fee schedule code. Each physician directly involved in CTO services must complete the CTO Report Log, for each calendar month."

We mapped the OHIP data to the *Community Treatment Order (CTO) Information Record* data. This comparison identified a number of physicians who submitted none or only some of these forms with respect to their CTO initiation or renewal services.

Table 2: Physicians billing OHIP for whom some or no *Community Treatment Order (CTO) Information Record* forms were submitted

Specialty	Number of Physicians	OHIP Billing Code[6]		
		K887 (CTO Initiation)	K888 (CTO Supervision)	K889 (CTO Renewal)
Some CTO Record forms submitted:				
GPs	2	X	X	X
Psychiatrists	37	X	X	X
Sub-total	39			
No CTO Record forms submitted:				
GPs	27	X	X	X
Psychiatrists	6		X	X
Other[7]	4	X	X	
Sub-total	37			
Total	76			

The missing data creates a gap in the MOHLTC's *Community Treatment Order (CTO) Information Record* database. We included the data for codes K887 and K889 in our analysis of the CTO data (see section 4.1.2.1). Physicians' services billed under code K888 do not require the submission of a *Community Treatment Order (CTO) Information Record* form to the MOHLTC. However, in some instances, a physician billed for supervision services when we could find no record of a CTO in the database.

[4] October 1, 2005 Physician Fee Schedule.
[5] Independent Consideration (IC): Services listed in the (OHIP Fee) Schedule without specified fees are identified as "IC" and are given independent consideration by the medical consultant.
[6] Some or all of these physicians billed for these services.
[7] According to current College of Physicians and Surgeons of Ontario (CPSO) records, includes a specialist in internal medicine/haematology (one patient in 2003), a general surgeon (three patients in 2003), a specialist in obstetrics and gynecology (five patients in 2001), and a specialist in internal medicine/infectious diseases (71 patients during 2001 to 2003).

4.1.2 Community Treatment Order (CTO) Information Record database

4.1.2.1 Background

The *Community Treatment Order (CTO) Information Record* was developed to facilitate the CTO review requirement in Bill 68.

The Finance and Information Management Branch, Acute Services Division, MOHLTC maintains it. MOHLTC staff enters the data on these forms into an Access database. The accuracy of the forms and their completeness was not always checked during the period under review. For example, four 2004 records are missing the date of birth (in these cases the system defaulted to 1800 01 01), and a few transcribing errors were noticed. We were informed that different staff were assigned to enter this data during the 2001-2004 period, and that this may have contributed to the errors. Apparently, the same person has been entering the data since December 2004, and he tries to ensure accuracy. However, because some forms are typed and some are handwritten, the information that has been submitted is not always clear.

In addition, the MOHLTC does not receive forms for all CTOs. Some physicians and others who may be responsible for submitting them do not do so (see section 4.1.1). In addition, we were told anecdotally that at least one agency does not submit the form to the MOHLTC if their client asks them not to because of privacy concerns.

Between December 1, 2000 and February 28, 2005 the MOHLTC *Community Treatment Order (CTO) Information Record* database recorded 1,777 forms.

Table 3: Number of *Community Treatment Order (CTO) Information Record* forms recorded, by year

Year	Number of CTO Forms			
	First Issue	Renewal	Reissue	Total
December 2000	3			3
2001	103	5	2	110
2002	282	66	18	366
2003	276	132	50	458
Total	664	203	70	937
2004	437	176	103	716
January-February 2005	58	33	21	112
Date not in database	1	3		4
Possible duplicates				8
Total				1,777

The comparison between this database and the OHIP records for the period December 1, 2000 and December 31, 2003 indicates that an additional 305 forms should have been submitted with respect to the initiation of CTOs (OHIP fee schedule code K887) and 52 with respect to the renewal of CTOs (OHIP fee schedule code K889).

This increases the number of CTO issues, renewals or reissues from 937 to 1,294 between December 1, 2000 and December 31, 2003.

In addition, there were several instances where there were Consent and Capacity Board hearings yet no record of the CTO could be found in the *Community Treatment Order (CTO) Information Record* database.

4.1.2.2 Age, gender and geographic location profile of CTO clients (Including OHIP clients not in MOHLTC database)

The 1,294 CTOs issued between December 1, 2000 and December 31, 2003 represent 816 CTO clients. The following tables provide a summary by age range, gender and the geographic location of the hospital or agency where the CTO was initiated.

Table 4: CTO clients, by age and gender (December 1, 2000 to December 31, 2003)

Age Range	Male	Female	Total
Number of clients:			
15	1	1	2
16-20	15	6	21
21-30	112	33	145
31-40	115	95	210
41-50	99	107	206
51-60	55	46	101
61-70	20	37	57
>70	26	48	74
Total	443	373	816
Percentage of clients in age group:			
15	0%	0%	0%
16-20	3%	2%	3%
21-30	25%	9%	18%
31-40	26%	25%	26%
41-50	22%	29%	25%
51-60	12%	12%	12%
61-70	5%	10%	7%
>70	6%	13%	9%
Total	100%	100%	100%
Percentage male/female:			
Total	54%	46%	100%

Table 5: CTO clients by gender by hospital/agency location (December 1, 2000 to December 31, 2003)

Region Name*	Number of Clients		
	Male	Female	Total
Number of clients:			
Central East	44	31	75
Central South	21	12	33
Central West	43	23	66
East	47	31	78
North	42	43	85
Southwest	47	34	81
Toronto	202	199	401
Totals	*446	373	819
Percentage of clients:			
Central East	10%	8%	9%
Central South	5%	3%	4%
Central West	10%	6%	8%
East	11%	8%	10%
North	9%	12%	10%
Southwest	11%	9%	10%
Toronto	45%	53%	49%
Totals	100%	100%	100%

* This total is three more than that for Males in the previous table because in three instances the client had their CTO renewed in a different location than that in which the CTO was issued (Toronto/Central West, Toronto/Central East and Southwest/Central West).

4.1.2.3 Summaries of MOHLTC and OHIP data (December 1, 2000 to December 1, 2003)

Table 6: Total CTOs by health planning region, by year

Region Name*	Number of CTOs				
	2000	2001	2002	2003	Total
Central East		15	53	33	101
Central South		18	16	17	51
Central West	1	3	41	56	101
East		8	41	77	126
North		6	46	75	127
Southwest		17	70	87	163
Toronto	7	132	240	243	622
Totals	8	199	499	588	1,294

* See section 9.4 for a list of MOHLTC planning regions and the counties that are included within them.
* See section 9.4 for a list of MOHLTC planning regions and the counties that are included within them.

The following table provides a snapshot of the use of CTOs by hospital/agency across Ontario's health planning regions.

Table 7: Summary CTOs by hospital/agency, by year

Hospital/Agency	Region	Number of CTOs				
		2000	2001	2002	2003	Total
Lakeridge Health Corporation, Oshawa	CE					10
Markham-Stouffville Hospital	CE					10*
Mental Health Centre, Penetang (500 Church)	CE					28
Penetanguishene General Hospital	CE					*
Peterborough Regional Health Centre	CE					*
Rouge Valley Health System, Ajax	CE					10
Royal Victoria Hospital, Barrie	CE					26
Southlake Regional Health Centre, Newmarket	CE					8
Whitby Mental Health Centre						*
Sub-total Central East			**9**	**47**	**32**	**88**
Brant Community Healthcare System, Brantford	CS					*
Greater Niagara General Hospital, Niagara Falls	CS					*
Hamilton Health Sciences Corporation	CS					*
St. Catharines General Hospital	CS					7
St. Joseph's Health Care, Hamilton	CS					14
St. Joseph's Hospital, Hamilton	CS					*
Wellington Psychiatric Outreach Program, Hamilton	CS					*
Sub-total Central South			**11**	**14**	**15**	**40**
Credit Valley Hospital, Mississauga	CW					22
Halton Healthcare Services, Oakville	CW					*
Homewood Health Centre, Guelph	CW					*
Trillium Health Centre, Mississauga	CW					21
William Osler Health Centre, Brampton	CW					42
Sub-total Central West			**3**	**35**	**54**	**92**
Carlington Community and Health Service, Ottawa	E					10
Cornwall General Hospital	E					*
Frontenac Community Mental Health Services, Kingston	E					*
Hôpital Montfort, Ottawa	E					*
Hotel Dieu Hospital, Kingston	E					*
Providence Continuing Care Centre, Kingston	E					*
Quinte Healthcare Corporation, Belleville	E					*
Royal Ottawa Health Care Group (Brockville)	E					7

"*" Indicates volumes of six or less CTOs, which have been suppressed for privacy reasons.

Table 7: Summary CTOs by hospital/agency, by year continued

Hospital/Agency	Region	Number of CTOs				
		2000	2001	2002	2003	Total
Royal Ottawa Health Care Group (Ottawa)	E					46
The Ottawa Hospital	E					30
Sub-total East			**3**	**37**	**70**	**110**
District ACT Team, Kenora	N					*
Lakehead Psychiatric Hospital, Thunder Bay	N					7
Lake-of-the-Woods District Hospital, Kenora	N					*
North Bay Psychiatric Hospital	N					17
Northeast Mental Health Centre, Sudbury	N					57
Sault Ste. Marie General	N					22
Sudbury Regional Hospital	N					7
Thunder Bay Regional Hospital (McKellar)	N					9
Timmins and District General Hospital	N					*
Sub-total North			**6**	**46**	**74**	**126**
ACTT, Fergus	SW					*
Essex PACT Team, Windsor	SW					*
Hotel Dieu Grace Hospital, Windsor	SW					40
London Health Sciences Centre (Commissioners)	SW					*
Mercare Homes Inc., Strathroy	SW					*
PACT, Sarnia	SW					*
Regional Mental Health Centre, London	SW					28
Regional Mental Health Centre, St. Thomas	SW					*
St. Joseph's Health Care, London	SW					20
St. Joseph's Health Care, London (St. Thomas)	SW					16
Stratford General Hospital	SW					**7**
Sub-total Southwest			**16**	**45**	**61**	**122**
Centre for Addiction and Mental Health, Toronto	T					25
Centre for Addiction and Mental Health, Toronto	T					28
Centre for Addiction and Mental Health, Toronto	T					*
East Metro ACTT, Toronto	T					*
Humber River Regional Hospital, Toronto	T					7
Humber River Regional Hospital, Toronto (Keele)	T					50
Mount Sinai Hospital, Toronto	T					*
North York General Hospital, Toronto (Branson)	T					*
North York General Hospital, Toronto (Leslie)	T					82
Reconnect Mental Health Services, Toronto	T					*
Rouge Valley Health System, Toronto	T					35

Table 7: Summary CTOs by hospital/agency, by year continued

Hospital/Agency	Region	Number of CTOs				
		2000	2001	2002	2003	Total
Salvation Army Grace Hospital, Toronto	T					*
St. Joseph's Health Centre, Toronto	T					63
St. Michael's Hospital, Toronto	T					*
Sunnybrook and Women's College Health Science Centre, Toronto	T					*
The Scarborough Hospital, Toronto (General)	T					7
The Scarborough Hospital, Toronto (Grace)	T					11
Toronto East General and Orthopaedic Hospital	T					7
University Health Network, Toronto (General)	T					*
University Health Network, Toronto (Western)	T					8
William Osler Health Centre, Toronto (Etobicoke)	T					*
Sub-total Toronto		**3**	**60**	**143**	**153**	**359**
Sub-total Regions		**3**	**108**	**367**	**459**	**937**
Physicians billings to OHIP for CTO services for which no CTO forms were submitted to the MOHLTC		5	91	132	129	357
Total CTOs		**8**	**199**	**499**	**588**	**1,294**

The following tables provide inter-region comparisons of CTO usage by relating the number of CTOs issued in 2003 to the number of mental health hospital inpatient days and to the population aged 15 and older. These ratios were chosen because the MOHLTC has this data available in its databases. We would have also liked to use CTOs/1,000 mental health separations. However, a hospital is not required to differentiate between its various programs when reporting patient separations to the MOHLTC each month.

Table 8: 2003 CTOs by region per 1,000 mental health patient days, and per 100,000 population aged 15+

Region	# of CTOs 2003	Mental Health Patient Days		Population 15+*	
		#	CTOs/1,000	#	CTOs/10,000
Central East	32	239,827	0.13	1,753,280	1.83
Central South	15	109,497	0.14	980,130	1.53
Central West	54	870,210	0.06	1,858,450	2.91
East	70	268,975	0.26	1,355,480	5.16
North	74	159,103	0.47	714,860	10.35
Southwest	61	221,221	0.28	1,278,540	4.77
Toronto	153	310,576	0.49	2,165,280	7.07
Total	459	2,179,409	0.21	10,106,030	4.54

* Population figures as at July 2001 (Ontario Ministry of Finance).

Table 9: Who provided consent for the CTO?

Year	Consent by Client			Consent by Substitute Decision-maker			Sub-Totals	Not reported	Total CTOs
	Male	Female	Total	Male Client	Female Client	Total			
Number:									
2000	2		2	1		1	3		3
2001	28	21	49	40	20	60	109		109
2002	114	86	200	83	81	164	364	2F	366
2003	144	84	228	122	105	227	455	2F 2M	459
Totals	288	191	479	246	206	452	931	4F 2M	937

Table 10: Who provided consent for the CTO – Percentage by client and SDM totals?

Year	Consent by Client		Consent by SDM		Totals	
	#	%	#	%	#	%
2000	2	67%	1	33%	3	100%
2001	49	45%	60	55%	109	100%
2002	200	55%	164	45%	364	100%
2003	228	50%	227	50%	455	100%
Totals	479	52%	452	48%	931	100%

Table 11: Who provided consent for the CTO – Client and SDM, percentage by male and female?

Year	Male		Female		Totals	
	#	%	#	%	#	%
Consent by Client:						
2000	2	100%	0	0%	2	100%
2001	28	57%	21	43%	49	100%
2002	114	57%	86	43%	200	100%
2003	144	63%	84	37%	228	100%
Totals	288	60%	191	40%	479	100%
Consent by Substitute Decision-maker:						
2000	1	100%	0	0%	1	100%
2001	40	67%	20	33%	60	100%
2002	83	51%	81	49%	164	100%
2003	122	54%	105	46%	227	100%
Totals	246	54%	206	46%	452	100%

Table 12: Who provided consent for the CTO, by region?

Region	2000		2001		2002		2003		Totals
	Client	SDM	Client	SDM	Client	SDM	Client	SDM	
Number of CTOs:									
Central East			5	4	34	13	28	4	88
Central South			5	7	7	7	9	3	38
Central West			2	1	29	6	39	15	92
East			1	2	15	21	31	41	111
North			3	3	30	16	45	28	125
Southwest			5	11	20	26	28	33	123
Toronto	2	1	28	32	65	75	48	103	354
Totals	2	1	49	60	200	164	228	227	931
Percentages:									
Central East			56%	44%	72%	28%	88%	13%	
Central South			42%	58%	50%	50%	75%	25%	
Central West			67%	33%	83%	17%	72%	28%	
East			33%	67%	42%	58%	43%	57%	
North			50%	50%	65%	35%	62%	38%	
Southwest			31%	69%	43%	57%	46%	54%	
Toronto	67%	33%	47%	53%	46%	54%	32%	68%	
Totals	67%	33%	45%	55%	55%	45%	50%	50%	

Table 13: CTOs by issue or renewal (includes *Community Treatment Order (CTO) Information Record* forms and OHIP clients not MOHLTC in database)

Year	MOHLTC Database				OHIP			Total CTOs
	First Issue	Renewal	Reissue	Total CTOs	Initiation	Renewal	Total CTOs	
2000	3			3	5		5	8
2001	102	5	2	109	79	11	90	199
2002	282	66	18	366	120	13	133	499
2003	277	132	50	459	102	27	129	588
Totals				937			357	1,294

Table 14: Number of psychiatric hospitalizations for each client in six months prior to current CTO

Year	Total CTOs	Number of psychiatric hospitalizations for each client										
		1	2	3	4	5	6	7	8	9	33	0 or unknown*
Number:												
2000	3	2		1								
2001	109	47	31	14		1			1	1		14
2002	366	173	87	30	13	1	1		2			59
2003	459	189	94	28	9	5		1		1	1	131
Total	937	411	212	73	22	7	1	1	3	2	1	204
Percentage of total hospitalizations:												
2000	100%	67%		33%								
2001	100%	43%	28%	13%		1%			1%	1%		13%
2002	100%	47%	24%	8%	4%				1%			16%
2003	100%	41%	21%	6%	2%	1%						29%
Total	100%	44%	23%	8%	2%	1%						22%
Percentage of hospitalizations excluding 0 or unknown):												
2000	100%	67%		33%								
2001	100%	49%	33%	15%		1%			1%	1%		
2002	100%	56%	28%	10%	4%				1%			
2003	100%	58%	29%	9%	3%	2%						
Total	100%	56%	29%	10%	3%	1%						

* The MOHLTC instructions for the *Community Treatment Order (CTO) Information Record* include the following statement: Total number admissions to an inpatient psychiatric service that the patient has had in the six months prior to the date of issuing the current CTO. The "0 or unknown" column, therefore, includes an unknown number of CTO clients whose CTOs are being renewed and who had no hospitalizations during the currency of the previous CTO.

Table 15: CTO client service involvement in six months prior to current CTO

	Total CTOs	Hospital Inpatient Psychiatry	Hospital Outpatient Psychiatry/Mental Health	Medication Management/Clinic	Crisis Intervention	Assertive Community Treatment (ACT)	Addiction Service	Private Psychiatrist	Supportive Housing	Non-Psychiatric Medical Care	Community Mental Health Program	Emergency Room	None	Don't Know	Other
		Number of clients involved with each service*:													
2000		3	2	1	1	1			1	1		2			
2001		100	35	14	33	24	4	13	12	13	23	30			11
2002		273	129	39	50	60	7	31	36	34	100	78	7	1	36
2003		285	156	54	45	92	2	47	56	32	140	72	12	4	45
Total		661	322	108	129	177	13	91	105	80	263	182	19	5	92
		Percentage of clients involved with each service:													
2000	3	100%	67%	33%	33%	33%			33%	33%		67%			
2001	109	92%	32%	13%	30%	22%	4%	12%	11%	12%	21%	28%			10%
2002	366	75%	35%	11%	14%	16%	2%	8%	10%	9%	27%	21%	2%		10%
2003	459	62%	34%	12%	10%	20%		10%	12%	7%	31%	16%	3%	1%	10%
Total	937	71%	34%	12%	14%	19%	1%	10%	11%	9%	28%	19%	2%	1%	10%

* Because some clients were involved with more than one service during the six months prior to the current CTO, the number of clients involved with each service adds up to more than the total number of clients in each year.

Table 16: Services to be involved in the current CTO

Date	Total CTOs	Hospital Outpatient Psychiatry/Mental Health	Crisis Intervention	Medication Management/Clinic	Assertive Community Treatment (ACT)	Case Management	Supportive Housing	Addiction Service	Private Psychiatrist	Non-Psychiatric Medical Care	Community Mental Health Program	Other Services
		Number of clients to be involved with each service:										
2000		2			2	1	1		1			
2001		69	7	27	34	43	19	10	11	14	25	20
2002		226	22	102	84	202	51	18	41	43	132	30
2003		263	41	94	132	229	69	7	56	39	134	68
Total		560	70	223	252	475	140	35	109	96	291	118
		Percentage of clients to be involved with each service:										
2000	3	67%			67%	33%	33%		33%			
2001	109	63%	6%	25%	31%	39%	17%	9%	10%	13%	23%	18%
2002	366	62%	6%	28%	23%	55%	14%	5%	11%	12%	36%	8%
2003	459	57%	9%	20%	29%	50%	15%	2%	12%	8%	29%	15%
Total	937	60%	7%	24%	27%	51%	15%	4%	12%	10%	31%	13%

Table 17: CTO client involvement with legal system in six months prior to current CTO

Date	Total CTOs	Apprehended under the Mental Health Act	Criminal Arrest	Incarcerated	Probation and/or Parole	Victim of Crime	Court Diversion	None	Don't Know	Other Legal Involvement
		Number of clients involved with each aspect of legal system:								
2000		1	1	2	2		1			1
2001		44	16	5	26		3	42	3	6
2002		144	23	14	24	1	12	167	27	18
2003		178	14	6	27	1	9	228	25	13
Total		369	54	27	79	2	25	437	55	38
		Percentage of clients involved with each aspect of legal system:								
2000	3	33%	33%	67%	67%		33%			33%
2001	109	42%	15%	5%	24%		3%	39%	3%	6%
2002	366	39%	6%	4%	7%		3%	46%	7%	5%
2003	459	39%	3%	1%	6%		2%	50%	5%	3%
Total	937	39%	6%	3%	8%		3%	47%	6%	4%

Table 18: Psychiatric diagnoses on assessment prior to current CTO

Date	Total CTOs	Schizophrenia	Schizoaffective Disorder	Bipolar Disorder	Other Psychotic Disorder	Substance/Alcohol Related Disorder	Depression	Personality Disorder	Development Disorder	Other Disorders
		Number of clients with each psychiatric diagnosis:								
2000		3				1				
2001		68	21	12	6	10	2	4		6
2002		236	56	60	13	21	9	14	8	16
2003		323	60	53	13	19	6	10	4	15
Total		630	137	125	32	51	17	28	12	37
		Percentage of clients with each psychiatric diagnosis:								
2000	3	100%				33%				
2001	109	62%	19%	11%	6%	9%	2%	4%		6%
2002	366	64%	15%	16%	4%	6%	2%	4%	2%	4%
2003	459	70%	13%	12%	3%	4%	1%	2%	1%	3%
Total	937	67%	15%	13%	3%	5%	2%	3%	1%	4%

Table 19: Usual CTO client living arrangement prior to current CTO – Client Lives With

Date	Total CTOs	Spouse/Partner	Parent(s)	Child(ren)	Other Family	Non-Family Person	Self	Don't Know
		Number of clients with each living arrangement*:						
2000	3					2	1	
2001	109	7	31	4		16	50	1
2002	381	43	80	16	19	60	158	5
2003	475	35	92	12	26	73	218	19
Total	968	85	203	32	45	151	427	25
		Percentage of clients with each living arrangement:						
2000	3					67%	33%	
2001	109	6%	28%	4%		15%	46%	1%
2002	366	12%	22%	4%	5%	16%	43%	1%
2003	459	8%	20%	3%	6%	16%	47%	4%
Total	937	9%	22%	3%	5%	6%	46%	3%

* There are multiple checks on some forms, e.g., living with Spouse/Partner and Child(ren), which accounts for the "excess" of 31 (968 – 937) living arrangements.

Table 20: Usual CTO client living arrangement prior to current CTO – Housing Type

Date	Total CTOs	Private House/Condo	Market Rental Unit (apartment, flat or house)	Subsidized Rental Unit	Room and Board	Homes for Special Care	Approved Home	Retirement/Seniors Home	Hostel/Shelter	Correctional/Probation Facility	Other Institutional Facility (no fixed address)	Homeless/On Street	Don't Know	Other Housing
		Number of clients with each living arrangement:												
2000				1	1		1							
2001		29	32	12	2	1	3	2	2		1	3	8	14
2002		101	130	37	21	6	9	4	8		1	3	13	33
2003		131	114	77	34	11	11	7	9		1	1	24	39
Total		261	276	127	58	18	24	13	19	0	3	7	45	86
		Percentage of clients with each living arrangement:												
2000	3			33%	33%		33%							
2001	109	27%	29%	11%	2%	1%	3%	2%	2%		1%	3%	7%	13%
2002	366	28%	36%	10%	6%	2%	2%	1%	2%			1%	4%	9%
2003	459	29%	25%	17%	7%	2%	2%	2%	2%				5%	8%
Total	937	28%	29%	14%	6%	2%	3%	1%	2%			1%	5%	9%

4.1.2.4 Additional demographic data collected by CTO programs/coordinators

In order to provide a comprehensive profile of their CTO clients, many CTO programs collect demographic data that supplements that required by the MOHLTC. Because the data is collected and maintained in many different ways, it was not possible to cross-reference it on a CTO-by-CTO basis to the MOHLTC data.

Examples of the additional data that is collected are listed in the following table.

Table 21: Examples of additional demographic data collected by CTO programs/coordinators

Data Area	Detail
Date of Referral	
Client	Place of Birth
Medical diagnosis	
Gender	Other
Relationship Status	Single
	Married
	Divorced
	Widowed
	Common-law
	Separated
Race	Aboriginal/First Nations
	Black
	Caucasian
	South Asian
	West Asian
	East Asian
	Hispanic/Latin
	Middle Eastern
	Unknown
	Preferred not to answer
	Other
Culture	
Religion	
Language	First language
	Preferred language
Education	No formal education
	Some high school
	Completed high school
	Vocational training
	Some college/university
	Completed college/university
	Graduate level
	Post-graduate level
	Other

Table 21: Examples of additional demographic data collected by CTO programs/coordinators continued

Data Area	Detail
Employment	Full time
	Part time
	Occasional
	Unemployed
	Other
Source of income	
Housing	Private non-profit housing
	LTC facility/nursing home
	Psychiatric hospital
	Supportive housing
	Group home
	Boarding home
Current medications	Date
	Name
	Dosage/frequency
	Route
	Status
CTO not issued	Reasons/comments

We abstracted the following 2003 data from the additional demographic data provided to us by CTO coordinators:
Race: 53.5 per cent were identified as Caucasian, 12.6 per cent as Black, 11.7 per cent as Asian, 3.9 per cent as Aboriginal, 6.1 per cent were identified under various other categories, and 12.2 per cent as unknown.
Language: 36.6 per cent as English speaking, 6.9 per cent under various other categories, and 56.5 per cent as unknown.
Education: 33.0 per cent had some or completed high school, 28.7 per cent had some or completed college or university, 4.0 per cent were identified under other categories, and 34.3 per cent as unknown.

The data represents 230 CTO clients. Because it is incomplete, it should not be treated as representative of all CTO clients.

4.1.2.5 Reasons for not issuing CTOs

During the course of our interviews, we asked psychiatrists and others for the reasons why CTOs were not used or were refused. The results are set out in section 7.1. In addition to the other data that they collect, some CTO coordinators keep local data on why CTOs were not issued or were refused.
Some examples are:

- Client did not agree
- Psychiatrist not available in community to monitor the CTO client
- Accommodation problems
- Non-compliance issues
- Discharge before process completed
- Determined that CTO not appropriate
- Feasibility of expectations for support of community treatment plan
- Medication treatment issues
- Alternative discharge plans
- Transferred to another hospital
- Criteria not met
- Left hospital against medical advice
- Physician workload/time commitment
- Time required to issue a CTO
- Physician concerns over OHIP billing/data requirements

- SDM safety concerns
- Concern about negative impact on ongoing relationship to the CTO client
- Lack of demonstrated efficacy
- Concerns regarding infringement of rights
- Consent and Capacity Board decision.

4.1.2.6 Out-of-time CTO renewals

We analyzed the entries between December 1, 2000 and December 31, 2004 in the Ministry of Health and Long-Term Care database of *Community Treatment Order (CTO) Records* to establish when a CTO was renewed beyond the statutory six months, plus one month.

As previously stated, the quality of the data is known to be deficient. Consequently, some of the gaps between CTOs may have resulted from CTOs that are not included in the database. It is also possible that some of the out-of-time CTO renewals with a lengthy gap should have been classified as reissues, rather than renewals.

The following summary tables indicate that:
- no facility routinely renews CTOs beyond the statutory grace period of one month beyond the six months maximum term for a CTO
- most of the overages are probably caused by misclassification as renewals rather than reissues
- only a handful of CTOs appear to have been actually renewed a few days after their expiry date, which indicates that CTOs are virtually always renewed on time.

Table 22: Occurrences by mental health facility of overtime CTO renewals

Facility	Occurrences
1	2
2	6
3	3
4	1
5	1
6	2
7	1
8	1
9	1
10	5
11	2
12	2
13	2
14	3
15	3
16	1
17	2
18	1
19	1
20	1
21	1
22	1
Total[1]	43

[1] The difference in the totals between the occurrences by mental health facility of overtime CTO renewals and the distribution by days of delays in renewing CTOs is caused by four CTOs being renewed at a different hospital than that at which the prior CTO was issued.

Table 23: Distribution by days of delays in renewing CTOs

Days	Renewal of First Issue Overage	Renewal of Renewal/ Reissue Overage
1-5	5	2
6-10	4	
11-15	2	1
16-20		1
21-25	2	
26-30	1	
31-35		
36-40		
41-45		
46-50		
51-55	1	
56-60		
61-65		
66-70		
71-75		
76-80		
81-85		
86-90		
91-95		1
96-100		
101-200	9	5
200+	5	
Total	29	10

4.1.3 The Psychiatric Patient Advocate Office

We were asked by the Ministry of Health and Long-Term Care to comment on the following matter: Mechanisms and the effectiveness for provision of rights advice.

Section 33.1 of the *Mental Health Act* provides that a physician may issue or renew a community treatment order if a number of conditions are met. Included in those conditions are that the physician is satisfied that the person subject to the order and his or her substitute decision-maker, if any, have consulted with a rights adviser and have been advised of their legal rights or that the person himself or herself refuses to consult with a rights adviser and the rights adviser so informs the physician.

The Psychiatric Patient Advocate Office (PPAO) was established in 1983 as a provincial program to safeguard the rights and entitlements of persons in the provincial psychiatric hospitals. Today, the office provides its services

from its head office in Toronto, field offices in existing or former provincial psychiatric hospitals, and through community-based rights advisers who are located in close proximity to the psychiatric units of the community hospitals that they serve. All PPAO staff are independent from the facilities in which they work. The PPAO serves clients of the ten current or former provincial psychiatric hospitals and approximately 50 psychiatric units in community hospitals.

There are, however, a small number of general hospitals that provide in-house rights advice.

The tables that follow draw on data provided by the PPAO.

The following table illustrates the growth in community treatment order-related requests for rights advice ***where no substitute decision-maker is involved***, during the calendar years 2001 to 2004. It is based on the number of *Form 49s – Notice of Intention to Issue or Renew Community Treatment Order* that were issued.

Table 24: Form 49 requests for patient rights advice

Year	Community-Based Rights Advice			PPAO Field Offices			Facility-Appointed Rights Advisers			Total
	Issue	Renew	Total	Issue	Renew	Total	Issue	Renew	Total	
2001	65	0	65	40	3	43	19	10	29	137
Increase			371%			37.2%			127.6%	213.1%
2002	222	84	306	47	12	59	58	8	66	431
Increase			72.5%			54.2%			24.2%	55.2%
2003	298	230	528	79	12	91	42	8	50	669
Increase			32.6%			57.1%			10.1%	34.2%
2004	425	275	700	127	16	143	52	3	55	898

What this table illustrates is that the PPAO has been providing virtually all CTO-related patient rights advice since 2001. The facility-appointed rights advisers are serving a relatively constant number of clients, while the overall requirement for rights advice has grown significantly since CTOs were introduced in December 2000.

The next table shows the overall increase in Form 49s issued that were dealt with by the PPAO Community-Based Rights Advice staff, during the calendar years 2002 to 2004. The data is segregated between initial issues, renewals and those requests where a substitute decision-maker is identified. It does not include data on Form 49s dealt with by PPAO field office staff or facility appointed rights advisers.

Table 25: Patient and SDM requests for rights advice processed by PPAO Community-Based Rights Advice staff

Year	Issue	Renew	SDM	Total
2002	222	84	147	453
Increase				80.4%
2003	298	230	289	817
Increase				32.3%
2004	425	275	381	1081

The next table shows the response times for dealing with the Form 49s issued that were dealt with by the PPAO Community-Based Rights Advice staff, during the calendar years 2002 to 2004. As with the previous table, it does not include data on Form 49s dealt with by PPAO field office staff or facility appointed rights advisers.

Table 26: Response times to patient and SDM requests for rights advice processed by PPAO Community-Based Rights Advice staff[12]

	2002	Change	2003	Change	2004
Total:					
Within 3 days	246%	124.4%	552	47.1%	812
	57.4%		68.4%		75.6%
Within 7 days	119	64.7%	196	0.5%	197
	26.4%		24.3%		18.3%
>7 days	85	-30.6%	59	10.2%	65
	18.9%		7.3%		6.1%
Total	450	79.3%	807	33.1%	1,074
	100%		100%		100%
Issue:					
Within 3 days	163	63.2%	226	41.7%	377
	72.8%		89.9%		88.9%
Within 7 days	38	-44.7%	21	57.1%	33
	16.9%		7.1%		7.8%
>7 days	23	-60.9%	9	55.6%	14
	10.3%		3.0%		3.3%
Total	224	32.1%	296	43.2%	424
	100%		100%		100%
Renewal:					
Within 3 days	31	293.5%	122	46.7%	179
	38.8%		54.2%		65.3%
Within 7 days	27	207.4%	83	-12.0%	73
	33.7%		36.9%		26.7%
>7 days	22	-9.1%	20	10.0%	22
	27.5%		8.9%		8.0%
Total	80	181.3%	225	21.8%	274
	100%		100%		100%
SDM:					
Within 3 days	52	215.4%	164	56.1%	256
	35.6%		57.3%		68.1%
Within 7 days	54	70.4%	92	-1.1%	91
	37.0%		32.2%		24.2%
>7 days	40	-25.0%	30	-33.3%	29
	27.4%		10.5%		7.7%
Total	146	95.9%	286	31.5%	376
	100%		100%		100%

[12] The data in this table varies very slightly from the previous table as the data was compiled at different times.

This table indicates a general decrease in the number of days taken to provide rights advice. Notwithstanding the 140 per cent increase in the volume of requests, the service provided improved from 54.7 per cent of requests being processed within three days in 2002 to 75.6 per cent of requests in 2004, and from 18.9 per cent of requests taking more than seven days to process in 2002 to 6.1 per cent of requests in 2004. The general trend holds true whether the request is for a first issue, a renewal or there is an SDM identified, and in all areas of Ontario.

The PPAO explained that there are limitations to the conclusions that can be drawn from this data. The response times are divided into three categories of requests, that is, an issuance (person), renewal (person) or a substitute decision-maker. This differentiation is important as each category presents unique challenges to the provision of rights advice in a timely manner. Response times are impacted by many factors. Some factors are common to all three categories of requests and some impact only a specific category. Some of the factors influencing response times in all three categories are:

- information in the Form 49 and community treatment plan (CTP) unclear – need to clarify with requestor
- changes to the Form 49 and CTP by requestor made after original receipt
- person to receive rights advice has not received Form 49 and CTP
- arranging an interpreter
- incorrect contact information for person to receive rights advice.

The response times for requests for rights advice on the issuance of a CTO are frequently the lowest, because the vast majority of rights advice to persons being considered for the issuance of a CTO is provided while the person is an inpatient in a psychiatric facility. However, there are times when the person is not in the facility (e.g., on a leave) or has been discharged before the rights adviser attends. Some rights advice requests involve the proposed issuance of a CTO when the person is living in the community.

The response times for requests for rights advice on a renewal are influenced by factors such as:

- person is living in the community and not as readily available
- difficulty contacting the person to arrange a time for rights advice, e.g., no telephone, not home, does not respond to messages
- coordination with community support to meet person
- person does not live in a community where there is a rights adviser, e.g., on a reserve
- finding a convenient place to meet.

The response times for requests for rights advice to substitute decision-makers are influenced by factors such as:

- availability of substitute decision-makers (SDMs) to receive rights advice, e.g., on weekends, in the evening
- difficulty contacting SDMs, e.g., do not return telephone messages, not home, away
- SDMs do not fully appreciate the need for rights advice and are sometimes resistant
- difficulty if there is more than one SDM, i.e., use separate rights adviser for each SDM arranging rights advice at a distance, e.g., SDM is in another part of Ontario, Canada or another country.

The PPAO also recently carried out a limited satisfaction survey of CTO coordinators (40 surveys were sent out and 20 returned). The respondents were generally very satisfied with the service provided by the rights advisers. It should also be noted that the PPAO has recently surveyed facilities wherein it delivers rights advice. The results of that work is expected to be available within the next short period of time.

4.1.4 The Consent and Capacity Board

4.1.4.1 Data on hearings

Regional Psychiatric Review Boards were established in 1968. They were transformed into the Consent and Capacity Board in 1995. The board holds hearings to deal with specified issues under the *Health Care Consent Act*, the *Mental Health Act*, the *Substitute Decisions Act*, and the *Long-Term Care Act*.

Section 39 of the *Mental Health Act* requires the CCB, upon application or when a community treatment order is renewed for the second time and on the occasion of every second renewal thereafter, to inquire into whether or not the criteria for issuing or renewing a community treatment order are met. On hearing an application, the board is required to promptly review whether or not the criteria for issuing or renewing the community treatment order are met at the time of the hearing.

Under section 75 of the *Health Care Consent Act* the board is required to promptly fix a time and place for a hearing. The hearing must begin within seven days after the day the board receives the application, unless the parties agree to a postponement. Also, the board is required to render its decision and provide each party or the party's counsel or agent with a copy of the decision within one day after the day the hearing ends. The board is also required to produce written reasons for its decisions within seventy-two hours of a request by one of the parties to the hearing.

Notice to the board is given on Form 48 (Application to Board to Review Community Treatment Order (s. 39.1(1)), and Notice to Board by Physician of Need to Schedule Mandatory Review of Community Treatment Order s. 39.1(4)), i.e., on second renewals. Fee-for-service physicians attending reviews are paid $358 per three hour session and $716 beyond three hours, but no travel time.

Summary CTO activity data is available for 2001 and 2002. Detailed data is only available for those years by recovering all (i.e., CTO and other hearings) the board's 2000 to 2002 record boxes from storage, and then manually sorting through them to identify and pull the files for CTO hearings. Because of the extraordinary effort that would be required to obtain that data, it was decided to limit our analysis of lapsed time from the receipt of an application to the hearing date to the period January 2003 and March 31, 2005. This data is available through the board's data tracking/case management system. Although limited, it does provide a current view of the board's activities, while covering part of the period of the legislated CTO review.

The following table provides an overview of the number of Form 48s requested or mandatory reviews and the board's compliance rate with the legislated deadlines. The data provided by the board appears to contain a few minor errors, e.g., day and month reversals, possible duplicates, and there are missing dates for several files. However, these problems are not significant enough to affect the overall picture provided by the data.

Table 27: Number of CTO hearings reported by the Consent and Capacity Board between January 1, 2001 and March 31, 2005

Year	Region								Total
	Hamilton	Kingston	London	Ottawa	Penetanguishene	Sudbury	Thunder Bay	Toronto	
2001	1		4				1	11	17
2002	5		6	3	6	1	3	10	34
2003	3	10	10	8	6	5		5	47
2004	13		14	19	5	6	2	39	98
To March 31, 2005	5		2	5	2	4	1	11	30
Total	27	10	36	35	19	16	7	76	226

As mentioned above, it was decided to limit our analysis of lapsed time from the receipt of an application to the hearing date to the period January 2003 and March 31, 2005. The results of this analysis are summarized in the following table.

Table 28: Number of days from receipt of application to hearing date between January 2003 and March 31, 2005

Year	Region								Total	Percentages	
	Hamilton	Kingston	London	Ottawa	Penetanguishene	Sudbury	Thunder Bay	Toronto		of total	of known days
2003:											
=<7 days	1	9	9	2	2				27	57.4%	79.4%
>7 days	1	1	1		3	4			7	14.9%	20.6%
Unknown	1			6	1	1		5	13	22.7%	
Totals	3	10	10	8	6	5		5	47	100.0%	100.0%
2004:											
=<7 days	9		9	12	2	5		24	61	62.2%	62.9%
>7 days	4		5	6	3	1	2	15	36	36.8%	37.1%
Unknown	1			1					1	1.0%	
Totals	13		14	19	5	6	2	39	98	100.0%	100.0%
January 1, 2005 to March 31, 2005:											
=<7 days	3		1	1		3		8	16	53.3%	53.3%
>7 days	2		1	4	2	1	1	3	14	46.7%	46.7%
Unknown											
Totals	5		2	5	2	4	1	11	30	100.0%	100.0%
Summary:											
=<7 days	13	9	19	15	4	12		32	104		
>7 days	7	1	7	10	8	3	3	18	57		
Unknown	1			7	1			5	14		
Totals	21	10	26	32	13	15	3	55	175		

Because the 2001 and 2002 summary data captured the disposition of hearings, we were able to show the result of all Form 48 CTO applications to the board for the period January 1, 2001 to March 31, 2005. The column heading descriptions in the following table were those used in the data provided by board staff.

Table 29: Disposition of CCB hearings between January 1, 2001 and March 31, 2005

Year	Confirmed	Revoked/ Dismissed	Dismissed	Status changed	Invalid form	No jurisdiction	Withdrawn	Not recorded in database	Total
2001	5	1		1		8	2		17
2002	14			3		6	11		34
2003	35	3				2	2	5	47
2004	73	7	3	3	4	2	6		98
To March 31, 2005	23	2	2	1		1	1		30
Totals	150	13	5	8	4	19	22	5	226

4.1.4.2 Reissuing CTOs

Clauses 33.1(12) and (13) of the *Mental Health Act* state:

> (12) A community treatment order may be renewed for a period of six months at any time before its expiry and within one month after its expiry.
>
> (13) Upon the expiry or termination of a community treatment order, the parties may enter into a subsequent community treatment plan if the criteria set out in subsection (4) are met.

It should be noted that the reference in clause (13) is to a community treatment plan, not to a community treatment order. However, the provision has generally been interpreted as providing for a new community treatment order rather than the renewal of a previous community treatment order. On the MOHLTC *Community Treatment Order (CTO) Information Record*, this is referred to as a "reissue" and is defined as "a CTO that is not the first for the patient, yet is being issued after some time (>1 month) has lapsed without a CTO."

While this is a practical approach to unclear wording in the legislation, it creates a loophole for those who may want to avoid the CCB process and an issue where there is a desire to renew a CTO but, for whatever reason, it is not renewed on time – every CTO lapses if it is not renewed within seven months of being made. The legislation requires the CCB to hold a hearing on every second renewal of a CTO. However, if the CTO is not renewed on time, even if it is one day late, it lapses and the count of renewals for CCB hearing purposes starts over again. We assume that this is not the intention of these legislative provisions, which were put in place to protect the rights of the patient.

For the purposes of this study, it creates a problem when trying to establish the effectiveness of the CCB process within the CTO program. Many CTOs do not trigger a CCB hearing, as they would if the legislation had required all remade CTOs (i.e., renewed or lapsed) within, say, a 12-month period to be counted towards the requirement for a CCB hearing.

The following table on page 71 provides a summary of the data in the *Community Treatment Order (CTO) Information Record* database and the OHIP database.

Table 30: Summary of CTO issues, renewals and reissues (December 2000 to December 31, 2003)

	2000	2001	2002	2003
***Community Treatment Order (CTO) Information Record* database:**				
First Issue	3	102	282	277
Renewal		5	66	132
Reissue		2	18	50
OHIP database:				
Initiation (K887)	5	79	120	101
Renewal (K889)		11	13	28
Total CTOs	8	199	499	588

4.1.4.3 Matching CCB hearing data to Community Treatment Order (CTO) Information Record and OHIP data

We attempted to match the data on CTO hearings that was provided by the CCB with the data on CTOs in the *Community Treatment Order (CTO) Information Record* database and the supplementary data provided by OHIP. There were several records of CCB CTO hearings where there did not appear to be a corresponding CTO recorded in the *Community Treatment Order (CTO) Information Record* or the OHIP databases. This evidence supports the earlier observations about the incomplete data submissions to the MOHLTC.

4.1.5 Leaves of Absence

The Ministry of Health has collected data on leaves of absence for several years. From 1999-2000 to 2000-2001 it is only available for seven provincial psychiatric hospitals (Brockville, Hamilton, Kingston, North Bay, Penetanguishene, Thunder Bay [Lakehead], and Whitby. For 2000-2001 data is available for these hospitals and for the Centre for Addiction and Mental Health. From 2002-2003 data is available from the hospital daily census for provincial psychiatric hospitals and for general hospitals with psychiatric inpatient units. However, hospitals reporting under the daily census do not differentiate between mental health patients and patients of other programs.

The following table on page 72 provides a summary of the use of leaves of absence in excess of three days as reported to the MOHLTC.

Table 31: Authorized leaves of absence in excess of three days from reporting hospitals

Hospital			Year				
Name	**Type**	**Region**	**99/100**	**00/01**	**01/02**	**02/03**	**03/04**
			Number of returns from leave of absence during the year (# of patients, where known)			Average monthly number of patients on Leave of Absence	
Baycrest Hospital (Toronto)	MP	T				3.8	2.8
Brockville PPH	OP	E	230 (100)	238 (96)			
CAMH (Toronto)	MP	T			418 (240)		
Hamilton PPH	OP	CS	456	497			
Homewood Health Centre (Guelph)	MP	CW				2.6	
Kingston PPH	OP	E	562 (173)	436 (153)			
Lakehead PPH (Thunder Bay)	OP	N	136	166	132 (58)	14.5	7.3
North Bay PPH	OP	N	286 (160)	213 (122)	201 (116)	22.5	23.7
Penetanguishene MHC (Oakridge)	OP	CE	311			2.1	1.8
Penetanguishene MHC (Regional)	OP	CE			282 (173)	23.4	14.8
Providence Continuing Care (Kingston)	MP	E			250 (95)	29.6	23
Public General Hospital (Chatham)	AP	SW				12.3	
Regional MHC (St. Thomas)	MP	SW			207 (111)		
Royal Ottawa HC Group	MP	E				20.7	17.3
St. Joseph's HCS (Hamilton)	MP	CS			331	24.3	19.3
St. Joseph's HC (London)	MP	SW				57.6	55.2
St. Joseph's HC (St.Thomas)	MP	SW				26.3	16.8
Whitby MHC	OP	CE	472 (209)	496 (190)	532 (216)	29.4	31.1

Type: AP is a general hospital with a psychiatric unit; MP is a specialty psychiatric hospital; OP is a provincial psychiatric hospital.

As can be seen from the table, because data collection on leaves of absence has been evolving since 1999-2000, it is difficult to develop a picture over time that will provide an accurate picture of the use of leaves of absence as an alternative to CTOs.

4.1.6 Sessional Payments

The MOHLTC disburses funds to paymaster organizations that are to be used to make sessional fee payments to physicians. A session is three hours. A psychiatrist receives $358 per session and a general practitioner receives $266. Other time periods are prorated using the sessional rate.

The Ministry requires a semi-annual and an annual report on the sessional payments that provides information on the amount spent and the number of sessions for the following services:

- Case conferences
- Client consultation
- Staff consultation
- Program consultation
- Program direction
- Educational services
- System coordination

for the following programs:

- Emergency department and crisis program
- Inpatient programs
- Outpatient programs
- Day treatment programs
- Day hospital
- Community mental health programs
- Addictions programs
- Other community settings.

The identifying information in the report includes the name of the reporting program or hospital, the program number and program type.

As can be seen from the foregoing, CTO-related sessional fee payments can only be captured if a CTO program is specifically identified as a program for which physicians may receive sessional fees.

4.2 The Website

In early October of 2004, we established the "Community Treatment Orders: Ontario Legislated Review" website at **www.ctoproject.ca**. The website had a variety of objectives:

- Inform the public about the mandate and legislated requirements for the review
- Provide regular updates on the progress of the review
- Encourage participation in the local consultation process
- Make available a highly interactive online environment in which members of the public could easily relate to the project team
- Promoting participation in a Survey.

The site had the following major pages:

- Legislative Basis for the Review – which described the legislation and the mandate of the consulting team
- Our Approach to the Review – outlined the major elements in the review process
- Project Update Blog – providing regular updates during the entire review project
- Online Survey – posted in January 2005, this page provided direct online access to the survey
- Submission format for Agencies and Organizations – this was provided for those agencies wishing to provide written submissions
- Working Bibliography – encouraged readers to suggest articles and other material relevant to the review
- Profiles of the Principal Consultants – introduced the review team
- Links – were provided in response to visitors' requests and provided only an introduction to available material about CTOs on the Internet
- Contact Us – gave numerous options for providing feedback to the consulting team
- Privacy Policy – indicated protection of personal information was a priority and outlined what information was gathered about website visits
- PowerPoint presentation about the project by Michael Bay.

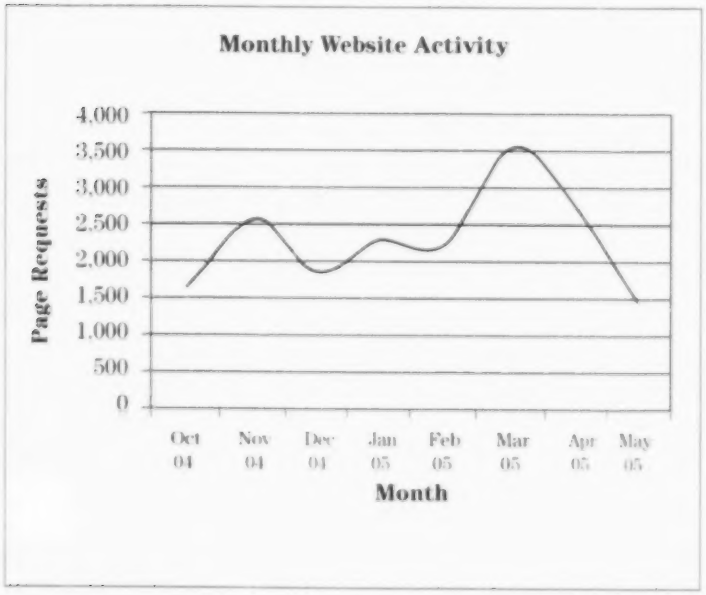
The following table summarizes some of the utilization data from the website dating from the beginning of October 2004 when the site "went live" until mid-May 2005.

Table 32: General website statistics

1.	Time of first request	Oct. 4, 2004 18:55
2.	Successful server requests	18,300
3.	Distinct files requested	72 Files
4.	Distinct hosts (IP Addresses) served	2,522
5.	Visitors providing e-mail address and requesting further contact	132
6.	Signing guest book	9
7.	Providing suggestions for the bibliography	16
8.	Providing suggestions for links	9
9.	Requests for notification of availability of survey	87
10.	Comments on the quality of the website	3
11.	Surveys completed	128
12.	Surveys begun but not completed	268

The Monthly Report identifies activity for each month in the report time frame. Note that each page hit can result in several server requests as the images for each page are loaded.

Table 33: Monthly website activity



Many organizations provided links to the www.ctoreview.ca website. They included:

- Canadian Mental Health Association
- Centre for Addiction and Mental Health
- Consent and Capacity Board
- Ontario Case Managers Association
- Mood Disorders Association of Ontario
- Ontario Association of Chiefs of Police
- Psychiatric Patient Advocate Office
- Ontario Medical Association

4.3 The Survey

On March 13, 2005, a survey was posted on the project website (See section 9.3). A printable version of the survey was also posted on the website. Automated web-based software from QuestionPro.com was used to build the survey, collect the data and assist in the analysis.

The survey was intended for individual input, not for organizations. It was anticipated that the survey would supplement and reinforce the results from the personal interviews. We recognized that the survey methodology would not follow a rigorously scientific process. However, we wanted to ensure as broad a participation in the review as possible and the survey was intended to contribute to that objective.

The survey was formulated after several months of field interviews had taken place. This allowed some questions to be worded in a way that reflected commonly used phraseology and concerns found during our fieldwork. Questions calling on the respondent to agree or disagree with statements made were formulated randomly in positive or negative terms.

Participation in the survey was less than expected given the general interest expressed in it. There were 268 who began but did not complete the survey and 128 who completed the survey. The high drop out rate is partly attributed to individuals who viewed the survey and completed it at a later time.

We do not feel that the survey results are scientifically defensible as representative of the opinions of those with an interest in CTOs. However, we found the results remarkably consistent with the results we obtained through the in-depth interview process and have therefore reproduced some of the conclusions here for the interest of the reader.

Respondents ranked the following as the most important factors limiting the use of CTOs in Ontario – in order of importance:

- Insufficient community resources available for clients on CTOs
- Workload concerns regarding issuing a CTO, the legal review process and/or supervising a CTO client
- CTOs are only useful for a limited client population
- Limited enforcement mechanisms available
- Level of knowledge and/or experience with CTOs.

Respondents ranked the following lowest in importance as factors limiting the use of CTOs in Ontario:

- New LOA[13] provisions under the *Mental Health Act* are a simpler alternative
- Concerns regarding compensation and/or liability
- Lack of scientific evidence.

Respondents ranked the following as the most important factors supporting or encouraging the use of CTOs in Ontario – in order of importance:

- Addressing treatment non-compliance
- Ensuring a team supported community treatment plan
- Reducing frequency of hospitalizations
- Access to additional resources like case management.

Respondents ranked the following lowest in importance as factors supporting or encouraging the use of CTOs in Ontario:

- Meeting legislated criteria
- Client request
- Family or SDM request.

[13] Leave of Absence

Respondents felt most strongly – either positively or negatively – about the following twelve statements. The statements are ranked in order of the strength of the opinion.

Table 34: Ranking of respondents most strongly felt statements

Rank	Agree or Disagree	Statement
1	Disagree	Mental health professionals are fully aware of the new Leave of Absence provisions
2	Agree	There should be more research on the appropriate use and outcomes of CTOs
3	Disagree	Physicians are adequately educated and informed about CTOs and related issues
4	Agree	The availability of income support and housing influences the effectiveness of CTOs
5	Agree	Rights Advice should also be available after the CTO is issued
6	Agree	Compensation, liability and paperwork issues deter physicians from using CTOs
7	Disagree	The use of CTOs has not reduced hospital readmission rates or lengths of stay for CTO clients
8	Disagree	CTOs take needed resources away from non-CTO clients
9	Disagree	The methods for dealing with non-compliance are satisfactory
10	Disagree	CTO treatment outcomes are being adequately evaluated
11	Disagree	The CTO program is effectively serving the aboriginal, rural, multicultural and francophone communities
12	Disagree	Rights advisers overstep their mandate

We also were interested in seeing which statements had the greatest unanimity of opinion and which were most contentious. We used the standard deviation of the responses to each statement as a measure of unanimity and diversity of opinion.

The survey identified the greatest differences of opinion with regard to the following ten statements. They are listed in order beginning with the greatest:

- CTOs should be a last resort when other treatment options have been explored
- The civil rights of CTO clients are adequately protected
- CTOs are an effective way of addressing the "revolving door" between the hospital and the community
- Rights advice provisions do not adequately protect consumers and families
- The legislation appropriately balances the need for treatment, care and protection with clients' liberty interests
- CTOs take needed resources away from non-CTO clients
- CTOs keep people out of hospital
- CTOs "lack teeth" and are difficult to enforce
- CTOs increase communication and understanding among service providers
- The use of CTOs has not reduced hospital readmission rates or lengths of stay for CTO clients.

4.4 Quantitative Measurements of the Effectiveness of CTOs

We were asked to respond to the following evaluative and outcome questions:

- The effectiveness of CTOs during the period under review
  - What effect do CTOs have on client well-being and satisfaction?
  - What services and supports are CTO clients receiving?
  - What are the factors impacting on the effectiveness of CTOs?
- Methods used to evaluate the outcome of any treatment used under CTOs
  - What client outcomes are being measured?
  - How are client outcomes being measured?

This section deals with the part of the answer that flows from the available quantitative data.

What effect do CTOs have on client well-being and satisfaction?

The data collected by the MOHLTC through the *Community Treatment Order (CTO) Information Record* does not include information on client well-being and satisfaction.

These types of outcome measures have been addressed in Ontario through a small number of local studies[14] that used local data collection, and questionnaires and focus groups to ask different groups (e.g., CTO clients, family members, physicians, and caseworkers) questions about the impact that CTOs had on the quality of people's lives, how effective the CTO appeared to have been, and the level of client and family satisfaction.

What services and supports are CTO clients receiving?

The MOHLTC *Community Treatment Order (CTO) Information Record* database identifies patient service involvement during the six months prior to the CTO, as well as the range of services to be received by each CTO client under their community treatment plan (see tables 15 and 16). Thus, data on the actual use of a service is only collected when a CTO is renewed or reissued. The information is identified under section eight of the *Community Treatment Order (CTO) Information Record* (patient service involvement during the previous six months). It should be noted that this form does not include information on a CTO client's frequency of use or the duration of the use of the services identified.

The use of services by CTO clients is summarized in the following table that incorporates the data from tables 15 and 16. This data covers all CTOs issued during the period December 1, 2000 to December 31, 2003. It, therefore, includes multiple CTOs for a client during that period and, as a result, some clients are included more than once in the count (see section 4.1.2.2).

Table 35: Summary of services used and to be used by CTO clients

Service	Service involvement in six months prior to current CTO		Services to be involved in the current CTO	
	Number of clients	Percentage of total clients (937)	Number of clients	Percentage of total clients (937)
Hospital inpatient psychiatry	661	71%	N/A	N/A
Hospital outpatient psychiatry/mental health programs	322	34%	560	60%
Assertive community treatment (ACT)	177	19%	252	27%
Addiction service	13	1%	35	4%
Crisis intervention	129	14%	70	7%
Case management	N/A	N/A	475	51%
Private psychiatrist	91	10%	109	12%
Medication management/clinic	108	12%	223	24%
Supportive housing	105	11%	140	15%
Non-psychiatric medical care	80	9%	96	10%
Community mental health services through a specified agency	263	28%	291	31%
Emergency room	182	19%	N/A	N/A
Other services[1]	92	10%	118	13%
None	19	2%	N/A	N/A
Don't know	5	1%	N/A	N/A

[1] Because of the local nature of these studies, the limited data available and/or the difficulty of compiling the data due to inconsistencies in reporting formats, we have not included their data in the report.

[2] "Other services" that were identified include: physician for injections/depot injection clinic, court diversion, occupational therapy, counselling, forensic services, self-esteem/anger management, Public Guardian and Trustee or other trustee for finances, shelter while waiting for supportive housing.

What are the factors impacting on the effectiveness of CTOs?

No Ontario data was available that identified a significant number of the factors affecting CTO clients, or that ranked and assessed their effectiveness. However, many examples of service utilization and the outcomes of CTOs are identified in other sections of this report.

What client outcomes are being measured?

There is limited MOHLTC data on this topic. It deals with the use of services, involvement with the legal system, and living arrangements.

The main outcome measure used in Ontario for a CTO client is regular monitoring by members of the support team to ensure compliance with the community treatment plan or that the expected results are being achieved for that individual.

In addition, the previously referred local Ontario studies reviewed data/information that includes some of the following:

- Client and family satisfaction
- Number of hospitalizations prior, during and after CTO
- Length of hospital stay prior, during and after CTO
- Legal involvement prior, during and after CTO
- Vocational involvement prior, during and after CTO
- Crisis service involvement prior, during and after CTO
- Outpatient psychiatric service utilization prior, during and after CTO
- Case management involvement prior, during and after CTO
- Level and type of housing support prior, during and after CTO
- Living situation prior, during and after CTO
- Income source and employment status prior, during and after CTO
- Medication formulation and utilization prior, during and after CTO.

How are client outcomes being measured?

Measuring the "outcome" of a CTO requires the collection of client-specific data and other pertinent information, both before and after the CTO. Because the health and consequential social problems faced by a CTO client are generally complex and inter-related, outcome measures have to encompass such things as: inpatient hospitalizations, housing/living environment, relationships with family and friends, education, employment, involvement in community activities, and feelings of well-being and satisfaction. The outcome measures will necessarily vary between CTO clients based on their individual circumstances.

Through its *Community Treatment Order (CTO) Information Record* the MOHLTC collects data on:

- the services received by a CTO client during the six months before the current CTO (see Table 15)
- the services to be involved in the current CTO (see Table 16)
- a CTO client's involvement with the legal system during the past six months (see Table 17)
- who a CTO client lives with (see Table 19)
- the type of housing occupied by a CTO client (see Table 20).

This data provides a very limited view of CTO client outcomes. For CTO clients who have more than one CTO, it is possible to establish whether there are changes in their utilization of the specified services, in their involvement with the legal system, and in their living arrangements. The following tables provide three examples of *Community Treatment Order (CTO) Information Record* reporting where there were at least four consecutive CTOs.[10]

[10] Details of a CTO client's involvement with the legal system and of their living arrangements have been summarized to ensure client anonymity.

Table 36: Examples of CTO reports for clients with consecutive CTOs

CTO Client "A"								
	First CTO		Second CTO		Third CTO		Fourth CTO	
	6 months prior to CTO	Planned for first CTO	Reported for first CTO	Planned for second CTO	Reported for second CTO	Planned for third CTO	Reported for third CTO	Planned for fourth CTO
Involvement with Legal System in Past Six Months	Yes		No		No		No	
Services:								
• Hospital Inpatient Psychiatry	X		X					
• Hospital Outpatient Psychiatry/Mental Health			X					
• Medication Management/Clinic	X				X	X	X	X
• Psychiatrist	X	X				X	X	X
• Doctor								
• Depot injection	X	X	X	X			X	
• Emergency Room	X							
• Case Management		X		X	X	X	X	X
Lives with:								
• Family	X		X		X		X	
Lives in:								
• Private House/Condo	X		X		X		X	

Table 36: Examples of CTO reports for clients with consecutive CTOs continued

CTO Client "B"								
	First CTO		Second CTO		Third CTO		Fourth CTO	
	6 months prior to CTO	Planned for first CTO	Reported for first CTO	Planned for second CTO	Reported for second CTO	Planned for third CTO	Reported for third CTO	Planned for fourth CTO
Involvement with Legal System in Past Six Months	No		Yes		Yes		Yes	
Services:								
• Hospital Inpatient Psychiatry	X				X		X	
• Hospital Outpatient Psychiatry/Mental Health	X	X						
• Medication Management/Clinic	X	X						
• Case Management	X	X			X	X		X
• Assertive Community Treatment			X	X	X	X	X	
• Supportive Housing					X	X	X	
• Non-Psychiatric Medical Care					X	X	X	
• Other Services: Not Specified								X
Lives with:								
• Family	X							
• Self			X		X		X	
Lives in:								
• Private House/Condo	X							
• Rental Unit			X		X		X	

Table 36: Examples of CTO reports for clients with consecutive CTOs continued

CTO Client "C"								
	First CTO		Second CTO		Third CTO		Fourth CTO	
	6 months prior to CTO	Planned for first CTO	Reported for first CTO	Planned for second CTO	Reported for second CTO	Planned for third CTO	Reported for third CTO	Planned for fourth CTO
Involvement with Legal System in Past Six Months	No		No		No		No	
Services:								
• Hospital Inpatient Psychiatry	X						X	
• Non-Psychiatric Medical Care	X	X			X			
• Medication Management/Clinic		X			X	X		
• Case Management		X	X	X	X	X	X	X
• Hospital Outpatient Psychiatry/Mental Health			X	X	X	X		X
Lives with:								
• Self	X		X		X		X	
Lives in:								
• Rental Unit	X		X		X		X	

As can be seen, this data is useful for identifying the range of services utilized, and for developing legal system and living arrangement profiles. However, it is too limited to address the broader question of client outcomes.

5.0 Interviews

A significant part of the review was to allow stakeholders to provide direct input through face-to-face meetings.

We visited all parts of Ontario: rural and urban, North and South, French and English. We conducted interviews in big cities such as Toronto, Ottawa, and London as well as smaller centres such as Kenora, Lindsay, Campbellford and Hawkesbury. A small number of interviews were conducted by telephone or closed circuit television.

We conducted over 250 individual and group interviews, including 34 meetings with clients and consumers, 37 meetings with families and substitute decision-makers, 66 meetings with psychiatrists, and 14 meetings with representatives of the justice system.

During these meetings we met with over 1,000 individuals, including 47 CTO clients, 93 consumer advocates and representatives, 84 family members, and 216 psychiatrists.

Interviewees included:

- CTO clients
- Consumers
- Family members
- Substitute decision-makers
- Consumer advocates
- CTO coordinators
- Lawyers representing both the consumer and the provider perspective
- The Ontario Medical Association
- The Ontario Psychiatric Association
- The Association of Ontario Physicians and Dentists in Public Service
- The Ontario Hospital Association
- The Association of General Hospital Psychiatric Services
- The Canadian Mental Health Association Ontario
- The Schizophrenia Society of Ontario and other family advocacy groups
- Consumer groups and consumer advocacy groups
- The Mental Health Legal Committee
- The Psychiatric Patient Advocate Office
- The Ministry of Community Safety and Correctional Services
- The Office of the Public Guardian and Trustee
- The Consent and Capacity Board
- The Ontario Review Board
- Psychiatrists and other physicians
- Mental health case managers and workers
- ACT Team members
- Housing workers
- Rights advisers
- Hospital and community program administrators
- Hospital discharge planners
- Consent and Capacity Board members
- Social service agencies
- Community care access centres
- Parole officers
- Police officers
- Judges
- Court workers.

Many interviews were one-on-one. Others were group sessions. In all cases, those attending were open and frank with their opinions. Many expressed their pleasure with this approach, as it was the first time that anyone had

directly asked their opinion on CTOs. In fact, for many people in small communities, it was the first time that anyone connected to the government had asked them for their thoughts on any aspect of health care policy.

While much of an interview was freeform, the following issues were canvassed. Questions were designed to elicit both the positive and negative experiences with CTOs and to produce useful recommendations for the future. The issues that were explored included the following:

- What effectiveness measures are in place?
- How effective is rights advice and what are the related issues?
- Does the legislation cover all of the appropriate population or is it under- or over-inclusive?
- Does the legislation appropriately balance the need for treatment, care and protection with clients' liberty interests?
- What factors have encouraged or dissuaded physicians, SDMs and consumers from proposing/entering/renewing CTOs?
- Are multiple renewals being utilized?
- Have CTOs proven to be a useful treatment modality?
- Have the lives of persons on CTOs been improved?
- Which clients are and which are not being placed on CTOs? Is this satisfactory or should the pool of suitable candidates be expanded or contracted? How could this be accomplished?
- How satisfactory is the method for dealing with non-compliance?
- Is the administrative burden of CTOs satisfactory or excessive?
- Are the legal safeguards in the legislation satisfactory, lacking or excessive?
- Is the legislative language easily understandable by stakeholders?
- What supports are CTO clients receiving? Are these adequate?
- What are the alternatives to CTOs? Which clients do they best serve? Are they adequate?
- How are leaves of absence under section 27 of the *Mental Health Act* being utilized?
- Do the rights advice provisions adequately project consumers and families?
- Are the legislative provisions workable?
- What are the factors that encourage or discourage practitioners from using the CTO provisions?
- Are adequate resources available to support CTOs?
- Are the CTO coordinators performing adequately? How could their role be improved?
- What are the factors that influence the success of failure of a CTO?
- Is the legal review of CTOs performing adequately? What are the strengths and weaknesses of the review process?
- Why are CTOs utilized more in some parts of the province than in others?

During the interviews, we revisited some of the initial concerns about the legislation and the introduction of CTOs in Ontario with the organizations that expressed them to establish whether and to what extent these concerns still exist. The initial criticism ran the gamut from a fear that the legislation is overly coercive and not respectful of human rights, to a concern that it is too respectful of rights at the expense of effective treatment, or that it is technically deficient.

5.1 Consumer Perspectives

In the course of our study, we met CTO clients, former clients, other consumers and consumer advocates across Ontario. We also received and incorporated the data from a consultation session with CTO clients conducted by a peer support group in Toronto. The richness of opinions and perspectives among these groups and individuals was remarkable. The opinions expressed at these meetings was as diverse and thoughtful as that heard at any other meeting during the course of the project. The courage on the part of some individuals to share the intimate details of their sometimes painful experiences was quite moving.

Many CTO clients expressed support for the CTO concept and for their own CTO. We heard from clients who believe that the CTO has turned their life around or kept them out of hospital. We met consumers who told us that they wish that they had been on a CTO in years past instead of spending so many years suffering until they gained the insight necessary to turn their lives around. Several clients told us that they liked their CTO because it allowed them access to case management or other services that they needed. Many CTO clients told us that they felt that they were a true part of the CTO team and that they had been consulted fully during all stages. Some clients and

former clients told us that the enforcement provisions of the act did not trouble them, as they were not needed in their case. Others told us that their awareness of the enforcement provisions had encouraged them to comply with their treatment during periods when their insight was less than ideal.

Some CTO clients and former clients told us that they had only consented to the CTO as a way to secure an early discharge from hospital but that they now felt that it had been very beneficial for them. Others informed us that they had consented to the CTO under this sort of pressure, that it had been of no benefit to them and they felt that the pressure that they had been subjected to compromised their basic human rights.

Other clients and former clients had told us of their discomfort with the mandatory hearing and their belief that it was not necessary in the case of a voluntary CTO. Others felt that it would have been sufficient if a rights adviser had met with them and confirmed that they did not wish the annual hearing. Some clients felt that rights advice as well as optional and mandatory hearings are necessary safeguards for their rights.

Some CTO clients and former clients took a much less charitable view towards CTOs than those referred to above. Some informed us rather vehemently that they saw the CTO as an affront to their dignity and autonomy and that it had not assisted them in any way. Some consumers told us that the specter of a CTO was regularly used as a threat in their region in order to ensure compliance among consumers in the community. We also heard that some consumers who are not on CTOs are led to believe that they are in order to ensure compliance.

We heard from a number of consumers who felt that CTOs should only be available for individuals who pose a risk of serious harm to others. It was their view that what they saw as a serious violation of fundamental human rights and dignity was not justified in other circumstances. Others felt that CTOs are a potentially valuable treatment modality for a small group of needy clients but that they have to be used much more selectively, that rules for informed consent need to be respected, and that other options should be fully explored before a CTO is utilized.

We were told that community treatment plans need to be more flexible and reflect the individual needs and wants of the individual client. We heard that CTOs should be seen primarily as a vehicle for providing a support system for the client and that there should be more emphasis on empathetic listening and the provision of services and less on forcing medication. Still others shared the view that CTOs, while potentially useful for certain individuals were so open to abuse and could result in such a complete loss of autonomy that they should be abolished.

We also heard from clients who felt that they were not treated with respect by their psychiatrists and case managers. There were complaints of not being listened to, of being patronized, of being ignored. Complaints also related to a rapid turnover in case managers, which resulted in the inability to build trusting, effective relationships. Some clients spoke of a lack of sensitivity exhibited in ways such as requiring the client to take medication in the presence of landlords or other third parties. In summary, these clients felt that elements of the process constituted a fundamental affront to their dignity and humanity.

Some clients, former clients, and advocates were troubled by what they saw as a lack of consultation with the client during the formulation of the treatment plan. Some told us that plans were often presented to clients as a *fait accompli*. Some clients felt that their plans were devoted exclusively to treatment compliance rather than providing a holistic proposal for their care in the community. Others felt that some plans, such as those requiring the client to live with a certain boyfriend or girlfriend, were a fundamental and unjustifiable encroachment into areas over which they should have full control. We were told that being put on a CTO without really being a part of the process and without being consulted or listened to is frightening and depressing.

At one meeting we were told that there can be no justification for the expansion of the use of CTOs unless and until proper scientific evidence is available to prove their effectiveness. The point was made that if a CTO is, indeed, a treatment modality; it should be subject to the same sort of rigorous analysis as other treatments in the medical world.

We heard from consumer advocates who are strongly of the view that the CTO tends to place too much emphasis on medication and other issues of importance to the treatment team rather than the client. By way of example, one advocate told us that many CTO clients would benefit from access to a YMCA or similar community fitness facility that they cannot afford. It was said that the cost of subsidizing the costs of such an arrangement would be minimal and arguably much more beneficial than many of the other services provided to the client. Consumers repeatedly made the point that services such as housing, income support and readily available counseling are essential and that CTOs are doomed to failure without them. We heard concerns expressed that CTOs are sometimes being used

as a stopgap when other services are not available or are in short supply.

One advocate pointed out that a significant portion of the population is relying on alternative medicine to address their various issues. He opined that CTO clients should have the same opportunities in this regard as other members of the community.

We also heard from consumers who were of the very strong view that current CTO practices appears to often ignore the research that indicates that consumers do better in the community when a fellow consumer is engaged as a peer support worker. It was suggested that this must be rectified if maximum value is to be derived from CTOs.

We heard again and again that access to resources is a fundamental issue. It was suggested that it is inappropriate to use CTOs to obtain scarce resources for a client and that the proper solution is to allocate sufficient resources in the first place.

We spoke with consumers who told us that they and their peers no longer seek out the support that they need because of a fear that police powers to apprehend have been increased and because they fear that seeking out help will lead to apprehension, hospitalization, placement on a CTO and, ultimately, forced medication. One informant told us that it is his view that the tragic death of a friend is attributable to such a chain of events.

It should also be noted that it was forcefully brought home to us that a sector of the consumer survivor community remains adamantly opposed to CTO on principle; a position, it would appear, rooted primarily in the adherents' original philosophical opposition to the scheme rather than experience since the inception of the program.

If there was common ground among the consumers that we met, it was on the issue of respect for their dignity and autonomy, the necessity to provide proper services to them, the need for easy access to rights advice and advocacy, and most of all, the absolute imperative that their voices be heard and that they play a meaningful role in the events that will affect their lives.

5.2 Family Perspectives

We met family with relatives on CTOs and those without. The perspectives of these two groups were quite different.

Those with family members on a CTO generally expressed great satisfaction with the program. Many family members told us in no uncertain terms that it was a CTO that turned the life of their loved one around. Many of these family members spoke of years of frustration, anger and helplessness prior to the CTO because of their inability to secure assistance for their family members. They overwhelmingly reported great progress for their family member once placed on a CTO, often speaking of re-engagement with the family and community, the achievement of stable housing and a very much changed and happier family member. Many of these family members had struggled for years to find suitable care for their relative and had successfully advocated for a CTO. These families consistently told us that the ability that the CTO generally gave them to obtain ongoing access to clinical information about their family was a key factor in their satisfaction.

One mother told us that she is certain that the CTO saved her son's life. She described a seriously delusional and paranoid son who had made a number of almost successful suicide attempts in the year before his CTO. She told us that he had become much happier and more stable on the CTO.

A father told us about a son who was a successful athlete and scholar and a highly thought of member of his community only to descend into mental illness. He told us that his son had done poorly until a CTO was instituted but that he had improved so much on a CTO that he had re-engaged with the family and found a job only to slowly deteriorate and eventually take his own life once the CTO expired.

Family members who had not succeeded in having their loved one placed on a CTO and their advocates presented a different picture entirely. We met many family members who are frustrated and angry with regards to CTOs. Many of them had believed at the time that the legislation was passed that CTOs would be available for their loved ones. They had believed that their days of searching for a route to have their loved one treated was coming to an end. Many complained that the legislation that was passed was not the legislation that they had expected. Others complained the psychiatrists in their locale have refused or neglected, for reasons that they find inexplicable, to put their loved ones on CTOs.

Some family members told us that patients have too many rights, that these rights are misplaced given the mental disorders that burden their relatives, and that these rights are preventing their relatives from receiving treatment. Others blamed consumer advocates, the Canadian Mental Health Association or lawyers for their failure to obtain care for their loved ones. What was remarkable on occasions when we heard comments such as these was the level of frustration and despair and the deeply held belief that something or someone has prevented the creation of a program that could, at long last provide hope for their ill relatives.

One family member told us that lawyers, doctors, and advocates debate philosophy while they and their ill family member suffered.

It was suggested that one source of the problem that prevents their relatives from receiving the assistance that a CTO would provide is the fact that significant amounts of legal assistance and advocacy are available for consumers but none is in place for family members. It was suggested that the playing field could be leveled by creating an advocate for families that could provide both systemic and case-by-case advocacy in an attempt to secure CTOs and other care for their relatives.

5.3 Aboriginal Issues

A number of informants confirmed that very few members of the aboriginal community are placed on CTOs. In northwestern Ontario, for example, a local mental health professional told us that the use of CTOs was viable within the extended urban boundaries but impossible because of a lack of support services in remote settlements. The same source told us that many aboriginal mental health issues arise from social causes and should be resolved on a social rather than medical basis.

One aboriginal source, also a highly trained mental health professional, responded that the aboriginal community has its share of individuals suffering from serious and persistent mental illness rooted in organic causes and that these individuals deserve the same level of service as other residents of the province. The same source told us that many First Nations have sophisticated support services in place to provide the assistance of allied mental health professionals to their members. The problems, according to this source, are related to a lack of the requisite history of hospitalization and the lack of sufficient liaison between the First Nations health services and urban mental health services. Other aboriginal sources in the north confirmed that support services are in place but that the connection between those services and the Schedule 1 facilities is tenuous at best. It was also noted that a very few CTO coordinators, who must each cover a catchment area of many thousands of square kilometres, serve vast stretches of central Ontario and Northern Ontario.

In southern Ontario we also were told that serious roadblocks exist to the use of CTOs with the aboriginal community outside of urban areas. According to a southern Ontario senior health professional working in the aboriginal community, many aboriginal Ontarians do not feel comfortable or welcome at the Schedule 1 facilities in their area. As a result, those suffering from serious and persistent mental illness tend to be dealt with in the community even when they reach a stage in their illness that would otherwise indicate hospitalization. For this reason, these individuals lack the requisite period of hospitalization needed to qualify for a CTO. During this discussion, it was emphasized that insufficient community mental health services are available in southern aboriginal communities.

5.4 Multicultural Ontario

We heard from our informants from the multicultural community that there are many specific issues that affect the use of community treatment orders amongst new Canadians and members of diverse cultural groups. We were told that there are sometimes circumstances that make CTOs particularly useful for members of certain groups and other situations when there are extra roadblocks to the use of a CTO.

According to our informants, consumers who come from cultures with a high degree of respect for authority may be particularly good candidates for a CTO. We were told, for example, about a client from such a culture who suffered from serious and persistent mental illness. Various attempts at addressing the client's needs had proven unsuccessful until a CTO was used. The client complied with the CTO in all respects and it was the view of the professionals involved that this was the case because the client's socialization required respect for rules and

authority. We also heard that the client's situation deteriorated rapidly once the CTO was allowed to lapse.

We also heard that CTOs might be very useful in focusing services for a client from a community whose members find it particularly difficult to obtain services as the result of a lack of translators or a generalized shortage of services. We were told that psychiatrists and other professionals, who might otherwise tend to shy away from such a client because of the difficulties in dealing with the person, would feel an obligation to make themselves available as the result of being named in the community treatment plan.

We also heard, however, that there are often factors that make it less likely in certain circumstances that a CTO will be used or be effective as it might otherwise be. For example, a new Canadian may have an extensive history of psychiatric involvement including hospitalization prior to arrival in Canada. Those hospitalizations, however, will not satisfy the requirement for inpatient status. There are also communities that, because of their members' propensity to deal with mental health issues at home, are not likely to see their members qualify for a CTO at the point when things reach a point where one would otherwise be indicated.

We also heard that initiating or renewing a CTO for a member of a cultural community with linguistic or other special needs may add burdens, such as the need to find difficult to locate translators, to the already complex and time consuming CTO process. This, in turn, is sometimes enough to convince the clinician not to initiate or renew the CTO.

We were informed that there are culturally sensitive mental health services but they are overburdened, under-staffed and under-funded. CTOs are sometimes used as a way to get resources that would otherwise not be available but there are also circumstances where a CTO will be less than optimally effective because the necessary services to support the client in the community and support wellness are simply not available.

5.5 The Mentoring Effect

We heard from a number of psychiatrists and other health professionals that CTOs often become a viable option in a hospital environment when a member of the clinical staff takes the lead. We heard that, in some cases, sessional funds have been used to encourage a member of the staff to take the lead. In other cases, a staff member with an interest in forensic mental health or community reintegration has simply taken the lead. The CTO lead is sometimes but not always the chief of psychiatry.

What is consistent among the sites we visited is that CTOs seem to become a clinical treatment of choice when a member of the clinical staff takes the lead. He or she becomes the expert and the consultant on all matters related to CTOs and often the educator as well. Perhaps more importantly, he or she demonstrates that CTOs are a viable clinical instrument and others soon follow suit.

5.6 CTO Coordinators

As part of the implementation strategy for CTOs, the Ministry of Health and Long-Term CTO coordinators, funded CTO coordinators across the province. They are attached to certain Schedule 1 Facilities or other organizations. While not statutorily mandated or even recognized, these individuals play a central role with regard to CTOs. In many locales, dedicated CTO case managers have also been hired to manage all or part of the CTO case load.

As we travelled across the province, we heard again and again that the CTO coordinators are performing at a high level and providing an essential service without which the program could not succeed. Many physicians told us that they would have found it impossible or near impossible to originate and supervise CTOs without the assistance of the coordinators. As a general rule CTO coordinators prepare the rather complex paperwork required for a CTO. They usually bring together the various services and professionals who will form the CTO team for a particular client.

In many cases, CTO coordinators have become the local experts in everything related to CTOs including legal issues and the availability of services. Many of them regularly present educational and outreach programs for health and helping professionals, consumers and families. In some hospitals, the coordinators participate in discharge planning meetings on a regular basis in order to assist other members of the team assess whether or not an individual is a potential CTO candidate. In other locales, they only participate if invited to do so.

As we travelled the province, we were told again and again, that CTOs would not be a viable treatment were it not for the availability, skill and commitment of the coordinators. It became very clear, however, that the service of coordinators was not consistent across the province. There is no overall coordination or supervision of the coordinators across the province. Although they are seen as the experts in all things related to CTOs they do not, themselves, have access to legal advice or other high level input. Many coordinators have been very successful in gathering statistics, carrying out basic research related to CTOs and conducting extensive outreach and education but this is not consistent and they lack back-up in this regard.

The coordinators have consistently requested some sort of process for obtaining education, summary legal advice, and promotion of best practices. Generally speaking, they do not support an arrangement whereby they would report to some central authority. They do, however, support the appointment of someone to coordinate education and to take on a clearing house function and the responsibility to assess and promote best practices.

It was also pointed out to us that there is no legislative foundation for the coordinator function. It was suggested that this be corrected.

5.7 The Rural Perspective

We were told that CTOs have occasionally been very effective in rural areas but that, by and large, they have not proven themselves to be an effective treatment modality in these parts of the province. Where there has been success, it has often been because of the availability of an institutionally-based psychiatrist to provide supervision and support to health care professionals in the area and to make occasional site visits.

We were told that much of the problem in rural areas relates to general lack of resources and services. It was felt that driving distances and other special challenges are not taken into account when funds are allocated. We also heard that the severe shortage of family physicians and the lack of psychiatrists in these areas made it very difficult to initiate or support CTOs.

We were told of areas with excellent liaison to the nearest Schedule 1 facility. We also heard, however, of areas with very poor communication with the Schedule 1. In one area, for example, staff at the local mental health agency told us that they are never involved in the hospital discharge planning process for their clients, or even told when a clients is being released from hospital. We were informed that several family practitioners in rural areas had undertaken the supervision of CTOs but had abandoned the process when it became too difficult.

The main problems in rural areas seem to relate to the small population and the huge geographic areas. It was suggested that a comprehensive system of support for professionals in these areas is likely to make a substantial difference.

As well as additional financial resources, there was some suggestion that experienced psychiatric nurse practitioners could make a significant contribution to these areas and possibly provide the ground work for successful CTOs. We also heard that distance mentoring schemes, whereby psychiatrists and academic centres provide support for rural areas, are viable options.

5.8 CTO Enforcement

The issue of CTO enforcement was raised at virtually every one of our meetings with health and helping professionals and police officials. With some significant exceptions, these professionals viewed the enforcement mechanism as deeply flawed.

The enforcement mechanism is found in section 33.3 of the *Mental Health Act*. That section sets out the procedure for apprehension of the CTO client in the event of suspected non-compliance with the order. It reads as follows:

Early termination of order for failure to comply
33.3 (1) If a physician who issued or renewed a community treatment order has reasonable cause to believe that the person subject to the order has failed to comply with his or her obligations under subsection 33.1 (9), the physician may, subject to subsection (2), issue an order for examination of the person in the prescribed form.

Conditions for issuing order for examination

(2) The physician shall not issue an order for examination under subsection (1) unless,

(a) he or she has reasonable cause to believe that the criteria set out in subclauses 33.1 (4) (c) (i), (ii) and (iii) continue to be met; and

(b) reasonable efforts have been made to,

(i) locate the person,

(ii) inform the person of the failure to comply or, if the person is incapable within the meaning of the *Health Care Consent Act, 1996*, inform the person's substitute decision-maker of the failure,

(iii) inform the person or the substitute decision-maker of the possibility that the physician may issue an order for examination and of the possible consequences, and

(iv) provide assistance to the person to comply with the terms of the order.

Return to physician

(3) An order for examination issued under subsection (1) is sufficient authority, for 30 days after it is issued, for a police officer to take the person named in it into custody and then promptly to the physician who issued the order.

Assessment on return

(4) The physician shall promptly examine the person to determine whether,

(a) the physician should make an application for a psychiatric assessment of the person under section 15;

(b) the physician should issue another community treatment order where the person, or his or her substitute decision-maker, consents to the community treatment plan; or

(c) the person should be released without being subject to a community treatment order.

Subsection 33.5(2) of the act provides as follows:

Appointment of other physician

(2) If the physician who issues or renews a community treatment order is absent or, for any other reason, is unable to carry out his or her responsibilities under subsection (1) or under section 33.2, 33.3 or 33.4, the physician may appoint another physician to act in his or her place, with the consent of that physician.

A physician with the authority and grounds to do so may put the section into effect by signing what is known as a Form 47 under the *Mental Health Act*. The executed form is then given to the police who are authorized by the act to apprehend the named person and take him or her to the physician who signed the order. As noted in the section, above, the physician must then examine the person in order to determine whether to execute a Form 1, enter into a new CTO or release the person without a CTO. The act is silent as to whether the original CTO remains in effect if none of these options is chosen.

The wording of subsection 33.3(4), its common interpretation, and the effect of that wording have been raised as an issue at the vast majority of our sessions with professionals. We heard in meeting after meeting that professionals have been told that the wording of the subsection means that, apprehension under the section automatically terminates the CTO and that the only choices at that time are to issue a new CTO, detain the person on the authority of a Form 1, or release the person into the community. While the matter awaits definitive court interpretation, it should be noted that the Consent and Capacity Board has, in fact, ruled on a number of occasions that apprehension on the basis of a Form 47 does, in fact, void the CTO.

The common understanding that the Form 47 process voids the CTO has had a number of effects. Firstly, it has caused many professionals to be cynical about CTOs in general, believing, as many have told us that "CTOs have no teeth." It has influenced many professionals to not use CTOs. It became clear in the course of our consultations that the disillusionment with the enforcement process is one of the primary reasons that physicians are not using CTOs in situations where they might otherwise be effective.

This interpretation of the effect of apprehension on the authority of a Form 47 has led to an apparently widespread practice of avoiding use of the Form 47 by finding other methods of apprehension such as the use of a Form 1. We also heard that some physicians are inclined to release the patient back into the community without a new CTO rather than go through the process of reissuing the CTO after apprehension on a Form 47. In one case that was brought to our attention, a patient died in troubling circumstances after being brought in on a Form 47 and then released in the belief that the CTO was no longer valid.

It should be noted that, while the great majority of these professionals believe the enforcement mechanism to be flawed, they differed as to the significance of the problem. These differences are attributable to the differing views

that the various professionals hold as to the importance of enforcement to the success of community treatment orders. The majority of the professionals with whom we spoke believe that enforcement is an important element of CTOs but not the paramount issue. Two other, smaller, groups of professionals believe either that enforcement is an ancillary issue of no great consequence or, on the other side of the debate, that enforcement is the essence of the CTO process and that the success of CTOs is directly tied to the strength or weakness of the enforcement mechanism.

We heard from a number of physicians and other health and helping professionals that the requirement that a person apprehended on the strength of a CTO be returned to the issuing physician is a serious deterrent to the use of CTOs. These physicians feel that the level of personal responsibility that they have with regards to CTOs is an unjustifiable imposition that potentially interferes with their ability to manage their practice and take time off. Some of these same physicians are concerned that the level of ongoing personal responsibility raises the level of legal exposure that they face. Several of these physicians point to the "attending physician" wording of the involuntary committal process as proof that workable alternatives to personal responsibility can be found.

Many professionals expressed the concern that the requirement that a person apprehended on a Form 47 be returned to the signing physician was causing problems if the client moved from the local area. They spoke of police reluctance to transport clients over long distances or take them to a specific physician rather than the closest hospital.

Many members of the police community also shared with us their concerns with regards to the enforcement process. These concerns are described, below, under the heading "5.9 The perspective of police and other players in the justice system."

A minority of professionals with whom we spoke believe that the act should allow for forced treatment in the event of non-compliance. Some went so far as to say that CTOs are meaningless without this authority. Some suggested that forced treatment should be allowed on site in the community. Others felt that the law should allow the patient to be apprehended and brought to a hospital or clinic for treatment. Equally strong feelings were expressed by a large number of professionals who oppose this view. They generally told us that forcing treatment under a CTO would alienate their clients, be an unjustified intrusion into the autonomy of these individuals and defeat their main purpose, which is to build a relationship of trust with the client. Many of them felt that forced treatment was simply unnecessary. These professionals are part of a sizeable group who believe that the success of a CTO lies in good discharge planning, the fostering of relationships between inpatient and outpatient professions that promote understanding and continuity of care, and the ability to create a framework that assigns roles and accountability for all involved.

Some professionals with whom we met felt that the current CTO regime was effective in dealing with a certain population, but that what was sometimes referred to as a "Tier Two CTO" was necessary to deal with seriously ill individuals totally lacking in insight and the ability or willingness to cooperate with a treatment plan. It was suggested by some that this instrument would likely require pre-approval by a court or the Consent and Capacity Board and that it would have strong enforcement and other provisions and ongoing legal review similar to that found in the Ontario Review Board System.

5.9 The Perspective of Police and Other Players in the Justice System

We received written input from several police departments. We met representatives from numerous departments around the province as well as a fair number of probation and parole officers. We also met with a representative from the Ministry of Community Safety and Correctional Services.

As with many other sectors, the view of CTOs held by professionals in the justice system varies markedly across the province. We found that a minority of these professionals are very satisfied with the program and believe it to be useful and effective while the majority find it flawed and in need of change.

The concerns and opinions of members of the justice system break down into two categories. The first of these involves issues related directly to the CTO program as it has unfolded. The second is a much wider frustration rooted in the belief that many people suffering from serious mental illness could but are not being diverted from the justice system to the mental health system with the assistance of a CTO. This issue is dealt with, below, under the heading "5.10 CTOs and the criminal process."

The Penetanguishene police shared with us their very positive experience with the CTO program. The told us that they are frequently listed in the community treatment plan and that this opens the channels of communication both with regards to information about the client and with the various health and helping professionals and organizations involved with the client. They told us that working as part of the CTO team allows them to develop a personal, non-adversarial relationship with the client and to interact with the client in non-crisis situations. Police members of the Hamilton Community Outreach and Support Team were equally positive about their CTO experience.

Many other police officers and officials, however, were less positive about their experience with CTOs. Many expressed frustration with the common interpretation that the CTOs lapse in the event of a Form 47 (Order for Examination Sections 33.3(1) and 33.4 (3) of the act) apprehension. Many police are also troubled by the requirement that the client be returned to the signing physician or designate. This has, on occasion, resulted in the necessity to transport clients over long distances. We heard that some police departments have resorted to transporting apprehended clients only so far as the geographic limits of their catchment area at which time they are transferred to another force for transportation to the signing physician or, in some cases, for transfer to still another department in a motorized form of hot potato until the client is eventually delivered to the signing physician.

We also heard of police departments who insist that hospitals pay private duty officers to apprehend persons on the authority of a Form 47. In other cases, the requirement that the client be brought to the signing physician is ignored and the person is delivered to the closest emergency unit. It should be noted that the authority of the hospital receiving a person in such circumstances is questionable at best.

Issues also arose relating to the nature and extent of police authority when attempting to apprehend individuals on the authority of a CTO. Neither a Form 1 (Application by Physician for Psychiatric Assessment), nor a Form 47, grants explicit authority to forcibly enter a dwelling house or other location during an apprehension under the *Mental Health Act*. It was pointed out to us, however, that there is a fundamental difference between entry under the traditional dangerous grounds provisions of the act and entry under the authority of Form 47. In the former case, entry is legally justified because the officer is obviously entitled to assume that immediate entry is necessary to prevent serious harm to an individual. In the latter it is not possible to make any such assumption. If this line of reasoning is correct, then officers would not have the right of entry and the efficacy of CTOs would obviously be reduced.

We also heard that many police officers are reluctant to become involved in *Mental Health Act* matters because of the long waits that they often experience when attending at the hospital after apprehending an individual under the act.

Many police representatives shared with us their cynicism about legislation that they see as lacking sufficient enforcement authority to achieve its goals.

5.10 CTOs and the Criminal Process

In the course of our consultations, we met numerous mental health, probation, police and policy professionals as well as family members who expressed a great deal of frustration and concern that individuals are ending up in the criminal justice system who, in their view, could be effectively dealt with under CTOs.

We met a psychiatrist who spends one afternoon a week working in a small office next to a courtroom as part of a mental health diversion project. She told us that she sees numerous individuals suffering from serious mental illness and who are constantly involved in minor criminal matters. She explained that their psychiatric care is often limited to the few minutes that she has to spend with them and the donated sample packs of anti-psychotic medication that she dispenses. She said that she has found it nearly impossible to have these individuals dealt with by the formal mental health system; they are often without addresses or OHIP cards, often lack housing and are frequently nomadic. Most have no family doctors or psychiatrists and the hospital-based psychiatrists are, in her experience, reluctant to assume their care. These individuals do not qualify for a CTO because, while their conditions are often long-standing, they usually have no history of successful treatment or hospitalization.

We heard from police officials who are troubled by the high number of clearly mentally ill individuals coming into contact with the law. Police officers are unhappy at being forced to participate in the criminalization of mentally ill

individuals. We were told that diversion from the criminal justice system must be available at every stage in the process.

We heard similar stories from frustrated probation officers who told us that a significant portion of their caseload consists of individuals who suffer from untreated serious mental illness. The probation offices find that the normal tools of probation often fail with clients because of the clients' frequent inability to follow through with the requirements of the probation order or, sometimes, even understand them.

We heard that many individuals coming out of jail at the end of their sentence appear to be ideal candidates for a CTO but are not considered because they do not have a connection with the mental health system and, in any case, have been in prison rather than hospital for the previous three years and, therefore, do not qualify.

We met with a forensic psychiatrist who is on staff of a Schedule 1 psychiatric facility and also does work in the courthouse. He has taken the initiative to set up an informal diversion program wherein accused persons with serious mental disorders can be placed on a CTO, often in conjunction with conditional release under the criminal justice system. He works co-operatively with the local CTO coordinator, court mental health diversion worker, crown attorneys, defence lawyers, and judges. He believes that his program has been effective in certain cases in successfully diverting persons out of the criminal justice system by creating for them a community framework with supervision and services that suit their needs while giving the various players in the criminal justice system a comfort zone to agree to the diversion plan in lieu of probable incarceration.

We also heard from probation officers and case managers who told us of a number of other cases successfully diverted form the criminal justice system in a manner similar to that described above.

5.11 Substitute Decision-makers

When the CTO scheme was legislated in Ontario, the Legislative Assembly chose to define CTOs as treatments under the *Health Care Consent Act* (HCCA). This had the effect of borrowing the substitute decision-making scheme found in that act. It should be noted, however, that there is a fundamental difference between a CTO substitute decision-maker (SDM) and other substitute decision-makers under the HCCA.

Substitute decision-makers under the HCCA often make momentous decisions on behalf of the subject person. They may be asked to decide if the person should be admitted to a nursing home or allowed to return to their own residence, whether complex surgery or powerful drugs will be administered, and sometimes even if the time for life-sustaining treatment has come to an end. They do not, however, have control over the facets of the subject's life that are beyond the parameters of the decisions that they are making under the act. To put it simply, an SDM is not in the position of a guardian or the parent of a small child.

A CTO substitute decision-maker is in a fundamentally different position from that described above. Unlike other treatments, a CTO exerts ongoing control, potentially over numerous facets of the client's life, many of which are outside of the areas that we would normally think of as being components of treatment. It follows, then, that a CTO SDM also has the capacity to exercise a great deal of control over numerous areas of life. It should also be noted that a CTO is, by its very nature ongoing and many CTO SDMs have specific responsibilities set out in the community treatment plan in addition to their original decision-making role. In addition to all of this, the *Mental Health Act* gives CTO SDMs extensive access to the client health information.

One should not underestimate the difficulties and challenges that families and caregivers face in dealing with needs of those close to them who suffer from serious mental illness. There is little doubt that most CTO substitute decision-makers fulfill their difficult responsibilities with care and devotion. It is equally clear, however, that the issue of CTO substitute decision-making merits careful attention given the factors noted above and given the fact that the effectiveness and success of a CTO will likely be closely linked to the issue of substitute decision-making.

A number of consumers and consumer advocates raised the issue of substitute decision-making with us. We heard about a small minority of substitute decision-makers being on a "power trip." We met a long-standing CTO client whose spouse is her substitute decision-maker. She told us that an already difficult and somewhat abusive relationship had become considerably more difficult and, from the client's point of view, frightening, since the spouse was given power under the CTO to control even more aspects of the her life and further solidify an already troubling power imbalance.

We also received input regarding a patient who stated that her substitute decision-maker was a parent from whom she had previously suffered abuse. We heard from CTO coordinators that some SDMs hold their authority "over the head" of the client. We also heard from other advocates and patient legal counsel that the issue of inappropriate substitute decision-makers was a known problem that has presented itself in a number of different cases since the inception of the CTO program. It was our sense that the issue is a fairly pervasive one.

We also heard that there are sometimes problems with the manner in which substitute decision-makers are informed of their responsibilities and the manner in which they carry out those responsibilities. Capable patients making decisions for themselves are not bound by any rules. The same cannot be said for substitute decision-makers. They are bound to make their decisions in accordance with the rules set out in section 21 of the HCCA. That section requires the SDM to respect the client's most recent capable wish if relevant in the circumstances, if it is not impossible to comply with, and if it is expressed at age sixteen or later. If there are no binding prior capable wishes, the SDM must make the decision after considering a number of factors set out in the section. These are as follows:

21.(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether the treatment is likely to,
   i. improve the incapable person's condition or well-being,
   ii. prevent the incapable person's condition or well-being from deteriorating, or
   iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

The SDM may not consider factors not on the list in making his or her decision.

When seeking substitute consent, a health practitioner is obliged by law to bring the substitute decision-making rules to the attention of the SDM. (See: *M., A. v. Benes*, Ontario Court of Appeal, November 1993, Paragraph 24: "When the words 'in accordance with this Act' are construed in a manner consistent with the Charter and afforded the fair, large and liberal interpretation they deserve to best attain the objects of the act, we are satisfied that s. 10(1)(b) does impose an obligation on health practitioners to ensure that SDMs understand the requirements of s. 21 of the act when deciding whether consent to a proposed treatment should be given or refused.")

It is our impression from our interviews that most physicians seeking consent for CTOs do not convey this information and are not, in fact, aware of their obligation to do so. We also understand, however, that the Psychiatric Patient Advocate Office does attempt to convey these rules to SDMs in the course of providing rights advice. We note, however, that the PPAO also told us that a number of SDMs have been somewhat less than totally cooperative with and attentive to rights advice. Of more concern, as well, is the fact that we were told that a number of SDMs have made it clear to the PPAO that they intend to make CTO decisions as they see fit regardless of prior capable wishes and other factors set out in section 21.

5.12 Payment of Physicians

The issue of payment for physicians was raised in the course of our consultations by both physicians and other health professionals and managers. It arose in a number of contexts. We heard a number of times that a fee-for-service physician working outside of the Schedule 1 environment would find CTOs to be a money losing proposition because of the amount of work required that is not compensated or compensated at a rate that effectively pays much less per hour than other work.

We heard that the extensive information demanded by the Ontario Health Insurance Plan (OHIP) each time a claim for payment is made dissuades physicians from claiming under the CTO tariff and may, ultimately, dissuade physicians from using CTOs altogether. More generally, we heard that doing CTO work was much less remunerative than other day-to-day options available to hospital-based psychiatrists and that this has influenced a group of psychiatrists of indeterminate number not to participate in this work. On the other side of the coin, we heard from a number of psychiatrists who acknowledged this reality but told us that it did not influence their willingness to take part in the CTO process.

The government has distributed sums of money to psychiatric facilities around the province to be used as sessional fees for physicians engaged in the CTO process. We were told in some areas that these funds have been very effective in facilitating CTOs by compensating physicians to give or attend educational events, prepare for CTO hearings, act as formal or information mentors for colleagues on CTO issues, and engage in other CTO-related activities. In some hospitals, we heard that these funds have been very effective and well spent. There appears, however, to be a degree of inconsistency across the province. We heard that local representatives of the Ministry of Health and Long-Term Care may authorize certain uses of these funds in one area of the province while their colleagues in another part of the province may refuse to allow the funds to be used for the same purpose. We also heard that these funds are not used at all in certain areas.

A number of physicians in one part of the province refused to meet with us unless paid to do so. This apparent unwillingness to engage in an activity of obvious potential importance to the system and the patients that they serve unless direct compensation was forthcoming obviously raises a number of troubling questions.

5.13 Quality Assurance and Consistency Across Ontario

As we moved across the province it became clear that there is nothing consistent about the use of community treatment orders. In some facilities, CTOs are not used at all. In others they are the treatment of choice and are used extensively. In some areas, a small percentage of psychiatrists use CTOs. In others, most do. In some hospitals the chief of psychiatry is committed to the CTO program, in others the chief is ambivalent at best. In some facilities, the CTO client base is more or less evenly divided between capable and incapable individuals. In other facilities CTOs are used exclusively or almost exclusively for individuals in one or the other of these categories.

In some areas, clients and substitute decision-makers are at the table and part of the team as the CTO is formulated. In others, clients and SDMs are presented with CTOs as a *fait accompli*. In some parts of the province, community treatment plans are comprehensive instruments for living in the community and the promotion of wellness. In others they relate primarily to issues surrounding medication. In some places, the professionals in the hospital and the community function as a closely-knit team. In other areas, the gulf between them is wider.

A large majority of the health professionals with whom we met felt strongly that it was wrong to see community treatment orders as a treatment suitable for most mental health clients. Many felt that it was ethically wrong to use a treatment such as a CTO unless clearly indicated and no other reasonable solution was at hand. In some areas, however, CTOs appear to be the treatment of choice, used in large numbers and often, it seems, as a way of gaining access to resources that would otherwise not be available to the client. Many psychiatrists and other health and helping professionals with whom we spoke believe that CTOs are inherently an intrusion into a client's autonomy and, therefore, should be used sparingly and only when demonstrably appropriate. Other professionals told us that do not believe that CTO clients pay a price in terms of personal autonomy.

In parts of the province, the local assertive community care team provides case management for CTO clients. In other areas, they do not. In some areas, case management for CTO clients is integrated into the local community care program. In other areas, dedicated CTO case managers manage most or all CTO clients. In other areas the picture is mixed. In some parts of the province, CTO case managers and coordinators are part of the same organization. In others, they are employed by different organizations. In some areas, the local CTO coordinators all report to the same organization. In others, each works for a different hospital or agency. In some areas there is a smooth transition from CTO case management to other services. In others, a client is often not provided with case management services for an extended period after their CTO expires until they reach the top of the waiting list for other services. The rate of CTO usage varies markedly across the province.

We were told that there are no province-wide guidelines for CTOs. Unlike civil committal with its built-in second opinion, review by the officer in charge, shared responsibility between the clinician and the hospital and informal

peer review, the CTO process has no such built-in mechanisms. The only review sanctioned by the act is a legal one at the Consent and Capacity Board. It was clear from the comments of numerous psychiatrists and others with whom we spoke that the board process is routinely and intentionally circumvented in many locales by accepting consent from clients of questionable capacity, avoiding CTOs for clients who are demonstrably incapable and allowing CTOs to lapse in order to avoid the mandatory review.

It became clear that CTO coordinators provide a certain degree of quality assurance in certain areas. In most localities, they are actively involved in vetting CTO candidates for suitability and for compliance with the process. In others, however, their role is much more limited. A minority of psychiatrists do not involve the coordinators in the process and there is no requirement that they do so. Even when the coordinators are enmeshed in the process, they do not have any province-wide guidelines, consistent source of guidance or access to legal advice or a body of knowledge other than what they have created for themselves.

5.14 The Paper Load

The creation of a CTO is a multi-stepped process. First of all, the community treatment plan must be proposed.

The number of different steps required and the amount of paperwork necessary to create and renew a CTO is clearly a major issue for many clinicians and other related professionals across the province. A good number of psychiatrists told us that the amount of paperwork and the number of steps is not a significant issue because the CTO coordinators handle the paperwork. Many others, however, while acknowledging the assistance of the coordinators, told us that the amount of paperwork and steps involved in creating and renewing a CTO is an important factor in dissuading them from issuing or renewing CTOs. It was suggested that forms be combined or eliminated and that the government consider whether it is possible to streamline the process.

Many clinicians also commented on the special OHIP CTO billing form. They told us that the form is so complicated and onerous that they ignore it and use other simpler but less remunerative billing codes when doing CTO work. It appears that this issue is creating a great deal of resentment in certain quarters and is a significant factor in dissuading clinicians from using CTOs.

5.15 Consideration of Less Restrictive Alternatives

Many professionals told us that they would not consider using a CTO unless other, less restrictive measures had been considered and rejected. Many others, however, told us that they do not regard community treatment orders as restrictive of personal liberty and appear not to engage in the process described above. As noted elsewhere in this report, for example, there appears to be a propensity in certain locations to use CTOs as a convenient way of moving the client to the head of the resource line.

5.16 Voluntary Consent to Community Treatment Orders

The community treatment plan lies at the heart of every community treatment order. The community treatment plan is defined as treatment for the purposes of the *Health Care Consent Act*. As with every treatment under that act, voluntary, informed, capable, non-coerced consent is required. The patient makes the decision to consent or not consent to the community treatment plan if he or she is capable for that purpose. If the patient is not capable, then that decision is made by the proper substitute decision-maker as determined by applying section 20 of the *Health Care Consent Act*.

Section 4 of the *Health Care Consent Act* provides that:

> "A person is capable with respect to a treatment . . . if the person is able to understand the information that is relevant to making a decision about the treatment . . . and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."
>
> It goes on to provide for a presumption of capacity and states that the practitioner is: "entitled to rely on the presumption of capacity with respect to (a patient) unless he or she has reasonable grounds to believe that the (patient) is incapable with respect to the treatment . . ."

The Ontario Court of Appeal has said that this means that the practitioner is entitled to rely on the presumption of capacity when reasonable to do so but may not bury his or her head in the sand. (Khan v. St. Thomas Psychiatric Hospital (1992), 87 D.L.R. (Fourth) 289.)

The requirement that treatment not be provided without proper consent is a fundamental principle of our law and is, in fact, required by international protocol to which Canada is a signatory. That protocol is entitled "Principles for the protection of persons with mental illness and the improvement of mental health care" and was adopted by the United Nations General Assembly resolution 46/119 in December of 1991.

In order to be legally valid, consent must be capable, voluntary and informed. The issue of voluntariness is of particular concern with regards to patients hoping to be discharged. Much of the health legislation passed in Ontario in the past fifteen years is based on a study commissioned by the provincial government Chaired by Professor David Weisstub and set out in a work titled, *Enquiry on Mental Competency: Final Report* published in 1990. The following comment appears on page 83 of that report:

> Voluntariness is especially relevant in the treatment of vulnerable individuals such as prisoners, the developmentally handicapped and mentally disordered, children and the geriatric population, especially when being treated in an institution. The treatment may be linked to coercive influences such as promises of freedom, increased privileges, remuneration, etc.... Finally, it may also be compromised by the nature of the power imbalances in the doctor/patient relationship and through the exercise of "expert" prerogative.

As we travelled the province, we heard from many clients that they had been treated as part of the team, engaged in the process of formulating the community treatment plan and, ultimately, had given their voluntary informed consent to the plan. Health and helping professionals told us of working closely with clients to formulate their plans. They told us, in fact, that anything less than this would result in an unhappy and uncooperative client and a failed CTO.

In other cases, however, we heard from clients who feel that they were coerced into signing the plan in return for release from hospital. Rights advisers and the Psychiatric Patient Advocate Office told us that many attempts at providing rights advice to patients are met with disinterest on the part of the patient who takes the position that he or she has signed the documents in order to secure release from hospital and is not interested in discussing anything that might interfere with that arrangement. Interestingly, we also spoke with psychiatrists who candidly told us that the promise of release from hospital is used routinely to secure patient consent.

We heard of cases where fully formulated treatment plans were presented to clients and substitute decision-makers on what they perceived to be a "take it or leave it basis."

We also heard from a variety of sources, particularly rights advisers, CTO coordinators and other allied health and helping professionals that, in some parts of the province, clients of highly questionable capacity are allowed to make their own decisions regarding CTOs so long as they agree to sign the community treatment plan.

Many front-line providers told us that they were under the impression that CTOs always required patient consent. In fact, many of these professionals were highly resentful of the fact that the law apparently contained this anomalous provision. The source of this misunderstanding quickly became clear. In the communities where this was the general understanding, we usually heard from a number of the local psychiatrists that they were well aware that the CTO provisions applied to both capable and incapable patients but that they were loath to make findings of incapacity or enter into CTOs on the strength of consent from a substitute decision-maker. They also informed us that this position was based on the desire to avoid the work involved in making findings of incapacity or, more frequently, an aversion to attending hearings of the Consent and Capacity Board.

5.17 The Technical Requirements for Issuing and Renewing a CTO

Subsection 33.1 (4) of the *Mental Health Act* sets out the prerequisites for a CTO as follows:

Criteria for order

(4) A physician may issue or renew a community treatment order under this section if,

(a) during the previous three-year period, the person,

(i) has been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three-year period, or

(ii) has been the subject of a previous community treatment order under this section;

(b) the person or his or her substitute decision-maker, the physician who is considering issuing or renewing the community treatment order and any other health practitioner or person involved in the person's treatment or care and supervision have developed a community treatment plan for the person;

(c) within the 72-hour period before entering into the community treatment plan, the physician has examined the person and is of the opinion, based on the examination and any other relevant facts communicated to the physician, that,

(i) the person is suffering from a mental disorder such that he or she needs continuing treatment or care and continuing supervision while living in the community,

(ii) the person meets the criteria for the completion of an application for psychiatric assessment under subsection 15 (1) or (1.1) where the person is not currently a patient in a psychiatric facility,

(iii) if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person,

(iv) the person is able to comply with the community treatment plan contained in the community treatment order, and

(v) the treatment or care and supervision required under the terms of the community treatment order are available in the community;

(d) the physician has consulted with the health practitioners or other persons proposed to be named in the community treatment plan;

(e) subject to subsection (5), the physician is satisfied that the person subject to the order and his or her substitute decision-maker, if any, have consulted with a rights adviser and have been advised of their legal rights; and

(f) the person or his or her substitute decision-maker consents to the community treatment plan in accordance with the rules for consent under the *Health Care Consent Act, 1996*.

These criteria were the subject of numerous comments during the course of our consultations.

Clause (4)(a) specifies that a candidate who has not previously been on a CTO must have been a patient on at least two occasions or for a cumulative period of at least thirty days during the previous three years. The clause does not distinguish between voluntary, involuntary, or informal patients. We heard from lawyers who act for patients that this provision has put them in a position wherein they are ethically required to advise clients who might benefit from hospitalization to secure a discharge as quickly as possible so as to avoid the possibility of a CTO. These lawyers told us that they are no longer in a position to encourage clients to seek voluntary hospitalization during a mental health crisis.

Probation and parole officers told us that this requirement prevents the use of CTOs for individuals suffering from serious and persistent mental illness, who are in desperate need of the sort of support provided by a CTO, but who have not been in hospital because they have been incarcerated. We also heard that the same issue arises for individuals from remote areas, aboriginal settlements and parts of the province where serious mental health issues are generally handled without admission to a Schedule 1 Psychiatric Facility.

A number of persons with whom we spoke raised concerns with regards to the implications of clause 33.1(4)(c)(ii). That clause specifies that a person who is not currently a patient in a psychiatric facility only qualifies for a CTO if the physician believes that he or she satisfies the criteria for Form 1, Application by Physician for Psychiatric Assessment, under the *Mental Health Act*. We were told countless times in the course of our consultations that this requirement presents two major problems.

The first of these problems relates to hearings before the Consent and Capacity Board. The test the board applies when reviewing a CTO requires it to determine whether the client meets the criteria for a CTO at the time of the hearing. Given the fact that it is very likely that the client will, by that point, be in the community, the board may not uphold the CTO unless satisfied that the client meets the Form 1 criteria at the time of the hearing. It should be noted that the board is obliged to apply this test at the hearing even if the test was not pertinent at the time the CTO was signed owing to the fact that the person was then an inpatient.

The second problem relates to the renewal of CTOs. Many family members and professionals told us that the effect of the Form 1 requirement is that only clients for whom the CTO has not been successful qualify for a renewal. This

is because the successful CTO client will likely have reached a stage where he or she is not a candidate for a Form 1. It was suggested that this problem could easily be remedied by replacing the current wording to the effect that the client is likely to qualify for a Form 1 within a specified period of time if not maintained on the CTO.

We were told that the requirement for consent from the client or a substitute decision-maker "in accordance with the rules for consent under the *Health Care Consent Act, 1996*" is a major contributing factor to the complexity and length of Consent and Capacity Board hearings. The board has interpreted the provision to mean that it is open to it to explore the numerous complex and time consuming issues that arise under and out of the HCCA. While board officials and others told us that the problem has considerably receded in the last year, it is clear that the length of CCB hearings is still considered by many to be a major issue. It was suggested that removing this provision from the act and allowing the rules of the HCCA to address the issue in the same manner that it does for all other treatment modalities could address the problem.

5.18 Rights Advice

Rights advice has been an integral part of mental health law in Ontario for many years. The principle is that a patient should receive rights advice when his or her rights are impacted in a way that gives rise to the right to apply to the Consent and Capacity Board or when another party has requested a hearing. This principle was honoured when the *Mental Health Act* was amended in 2000 to provide for CTOs. The amendments also provide for rights advice for substitute decision-makers.

Historically, rights advice in provincial psychiatric hospitals was provided by the Psychiatric Patient Advocate Office (PPAO) and elsewhere by duty counsel arranged through Legal Aid Ontario. The status quo changed in the spring of 1995 with the establishment of the Advocacy Commission and again with the abolition of the commission one year later. By 1996 the PPAO was still providing rights advice in provincial psychiatric hospitals while rights advice in other psychiatric facilities was provided by in-house rights advisers or rights advisers under contract to the institution. Over time, the PPAO has assumed responsibility for most rights advice in the province and in-house and other contract rights advisers have played a decreasing role. In addition to providing rights advice, the PPAO provides individual and systemic advocacy to patients in provincial psychiatric facilities and former provincial facilities.

The act now requires that rights advice be offered to potential CTO clients, capable and incapable, and to substitute decision-makers. This must be done after the community treatment plan is proposed but before it is signed. Rights advice is compulsory for substitute decision-makers but clients may refuse it. The overwhelming amount of CTO rights advice is provided by the PPAO.

Subsection 14.3(3) of the regulations to the *Mental Health Act* set out the responsibilities of a rights adviser when providing CTO rights advice as follows:

The rights adviser shall explain to the person and the substitute decision-maker, if any, the requirements for the issuance or renewal of a community treatment order, the significance of such an order, including any obligations that the person or the substitute decision-maker may be required to meet under the order.

The health and helping professionals with whom we spoke, including psychiatrists, other members of hospital staff, and CTO coordinators, were generally satisfied with the services of the Psychiatric Patient Advocate Office (PPAO) and the rights advice services that they provide. Most told us that rights advice was provided in a timely manner and the process was constructive and helpful. Many CTO clients and substitute decision-makers told us that they appreciated the rights advice that they received. With the exception of a minority of family members who oppose all forms of legal protection for patients, everyone we spoke with told us that rights advice is a necessary and positive part of the process. Most felt that the service provided by the PPAO was as good as or superior to rights advice provided from sources outside that office.

Numerous stakeholders, however, raised issues with regards to rights advice. Some family members told us that they found rights advice provided at the time of renewal of a CTO to be redundant and a waste of their time. Several family members told us with some degree of anger that rights advisers dissuaded their otherwise compliant relatives from agreeing to a CTO. Several people questioned the wisdom of spending public money to repeatedly provide rights advice to the same officials in the office of the Public Guardian and Trustee. A number of hospital professionals told us that the rights advice process slows down the CTO process in their facility.

For their part, officials of the PPAO maintain that each community treatment plan is unique and merits fresh rights advice even if the person has previously received rights advice with regards to a different plan. They are of the view that even officials of the office of the Public Guardian and Trustee should continue to receive rights advice for each community treatment plan in recognition of the unique nature of each plan.

The issue of telephone rights advice was raised by a number of participants. When a CTO is proposed for a capable patient, only one rights adviser is involved in the process. In order to avoid potential conflicts, two rights advisers are used when a substitute decision-maker is making the decision on behalf of the client. This presents logistical problems that, in some cases, are resolved by delivering rights advice to at least one of the recipients by telephone. Several CTO coordinators and rights advisers felt that this practice was less than optimal.

A number of consumer advocates and health professionals raised the issue of the timing of rights advice. CTO rights advice is provided before the community treatment plan is signed which, in turn, precedes the CTO, itself. An application to the Consent and Capacity Board, however, can only be made once the CTO itself has been issued. This means that the patient is not legally entitled to apply to the Consent and Capacity Board at the time that he or she receives rights advice with regards to that very possibility.

We were told that timing is also an issue because many inpatients are willing to sign anything in order to secure their discharge and only become interested in contesting the CTO once they are safely out of the hospital.

The PPAO maintains that the CTO provisions of the *Mental Health Act* do not require an examination of the community treatment plan or the community treatment order. They also hold that there is no provincial guidance regarding when a CTO should be issued or the content of a community treatment plan. This lack of guidance, in their view, creates a potential for violation of the legal rights of individuals being considered for CTOs. In light of these perceived problems, the PPAO head office requires that the proposed treatment plan be submitted to them for review prior to the provision of rights advice. Officials of the PPAO told us that this practice is in place so that they are in a position to understand and explain the plan to clients and their decision-makers and to providing non-binding input for the professionals with regards to the structure and contents of the plan.

Several participants in various parts of the province raised the issue of the PPAO review of the community treatment plan. From the point of view of many of the professionals with whom we spoke the PPAO is exercising a power of review and veto that they find very troubling. We heard that what the professionals view as important elements, such as a stipulated place of residence, are sometimes now left out of treatment plans either out of fear that their inclusion will be the subject of criticism by the PPAO, or in the belief that these elements are legally inappropriate because a PPAO representative has made comments to that effect.

Several health professionals told us that they are troubled by the refusal of rights advisers to provide the attending physician with a copy of a patient's application to the Consent and Capacity Board or even tell him or her whether such an application has been made. Representatives of the PPAO told us that they follow this practice out of respect for client confidentiality and out of a fear that health professionals will exert improper pressure on clients to withdraw their applications to the Consent and Capacity Board should they become aware of them. According to our informants, however, this practice creates animosity, confusion and inconvenience to health professionals and administrative staff and that this, in turn, is a factor in persuading physicians and others not to use community treatment orders when they otherwise might consider them.

5.19 The Marketing of Community Treatment Orders and the Term "Brian's Law"

Section 33.1(3) of the *Mental Health Act* speaks of community treatment orders as treatment or care and supervision for dealing with the classic revolving door patient. While it is clear from the section that CTOs are not exclusively meant for that group, no other group is singled out for mention. It is interesting, then, that a significant proportion of the stakeholders consulted stated the belief that the primary purpose of CTOs is to protect the public from mentally ill individuals who would otherwise pose a serious risk to public safety. This belief affects behaviour and attitudes in a number of ways.

Some mental health professionals in various parts of the province told us that they believe it improper to use CTOs with individuals who do not pose a serious risk to public safety. While some of these individuals took the view that

it is ethically inappropriate to use coercive measures in other circumstances, those who expressed this position generally based it on the belief that the legislation was intended to be used exclusively with this group. It appears that this view has contributed to the reticence on the part of some professionals and organizations to participate in the CTO program.

A number of mental health consumers told us that they would not want to be on a CTO because that status is associated with a dangerous, criminally-inclined population. Numerous health professionals, advocates, and consumers shared with us their discomfort with the term "Brian's Law" and the pejorative and misleading implications of that term. We were told that this adds to the already significant stigma of mental illness by feeding the public perception that mentally ill individuals are inherently dangerous or otherwise undesirable.

As noted elsewhere in this report, numerous family members of the mentally ill and health professionals expressed surprise and disappointment that CTOs are not focused on very ill and dangerous individuals Some of these individuals feel deceived because of the way that the program was initially presented.

It would appear that these attitudes and behaviours are related to the communications strategy chosen for the community treatment order program at its inception, particularly the name "Brian's Law" which is the official name of the package of amendments to the *Mental Health Act* passed in 2000 which includes the community treatment order provisions. It should be noted that this term refers to Brian Smith, a highly regarded Ottawa sports figure and broadcaster killed by a mentally ill individual. The communications strategy used at the time implied that the amendments were focused on the sort of individual who had perpetrated that crime and would prevent future incidents of this sort. It would not, of course, be appropriate for us to question the wisdom of the communications strategy initially chosen for these provisions. In hindsight, however, it has become clear that this strategy has had an overall negative effect on the acceptance and success of the program.

As discussed elsewhere in this report, experience has demonstrated that CTOs are effective with a somewhat different group. This has caused a troubling clash between perception and reality.

5.20 Suitability of Community Treatment Orders

At the time that CTOs were introduced into the *Mental Health Act*, many people assumed that they were going to be of general application. Almost all of the health and helping professionals with whom we spoke disagreed with this proposition. They told us that CTOs should properly be seen as one treatment modality among many. They felt that it was wrong to market or promote CTOs as anything more than that. Most told us that CTOs are a useful treatment primarily for the client who is inclined to follow rules and the client who is disorganized but easily directed.

CTOs are not particularly useful, we were told, for the client who is resistive to authority, suffering from substance abuse, or otherwise presents issues that are difficult or complex. Some professionals felt that this could be partially remedied by strengthening the enforcement mechanisms by, for example, introducing a jurisdiction similar to that exercised by the Ontario Review Board under the Criminal Code. Most, however, were of the view that CTOs, by their very nature, are not a suitable instrument for these individuals and amending the legislation would be a futile exercise.

5.21 Discharge Planning and Hospital-Community Partnerships

We heard from numerous individuals that much of the success of CTOs is attributable to the following factors:

- The process encourages comprehensive discharge planning involving both hospital and community-based professionals.
- The process encourages the strengthening of working relationships between community providers and hospital staff.
- The process encourages the formulation of comprehensive planning and written plans for clients involving multiple providers with specified responsibility and implied accountability for each one.

When discussing leaves of absence, we frequently heard that they are not as effective as they might be because they do not encourage the sort of planning and cooperation noted above.

In Chatham, we heard that these types of routine encounters and close working relationships were already in existence and functioning at a high level prior to the advent of CTOs. It is interesting to note that professionals in that city do not feel that CTOs would appreciably increase the quality of client care in the area.

In other areas, however, we heard that CTOs have served as a catalyst for the establishment of close working relationships and comprehensive, multi-party discharge planning with assigned roles and implicit accountability.

We asked why a working arrangement whereby early discharge planning involving community partners and comprehensive written plans setting out the responsibility of each party would not be just as beneficial if carried out without the framework of a CTO. In some cases we heard that the essential enforcement mechanism would be lacking. In the majority of these conversations, however, we were told that the idea is good one in theory but that without the CTO framework it is doubtful if the process would take place.

In summary, many of the professionals with whom we spoke were of the view that one of the chief benefits of CTOs is that that they encourage the sorts of hospital-community partnerships and comprehensive discharge planning that one would hope to find without them.

5.22 The Role of Education

The need for more education was a consistent theme that we heard throughout our travels across the province.

CTO coordinators asked for more education on the legal aspects of CTOs. They felt that such a program was essential for both themselves and for the physicians and other health and helping professionals involved or potentially involved with CTOs. They believe that such a program is an absolute necessity to assist all involved in properly carrying out their jobs and applying the law in a consistent, reliable, well informed manner. The coordinators are of the view that this educational program must be ongoing. They also believe that such a program would assist by creating a comfort level for the use of CTOs where it is currently lacking and by promoting respect for the rights of CTO clients and other consumers.

Many coordinators told us that the educational program should be coupled with easy access to summary legal advice for coordinators. The told us that they are seen as the knowledge source about CTOs, but they often lack consistent and reliable legal information to pass along. They also said that quick access to a source that can answer legal questions as they arise would make their jobs easier and more effective.

It also became clear during the course of our travels that there is a great deal of ignorance and unease amongst physicians with regard to the legal aspects of CTOs. The *Starson* case at the Supreme Court of Canada has created a great deal of misunderstanding across the province. Many clinicians have been given the erroneous impression that the rules for consent to treatment have somehow changed as the result of that case. In addition, many clinicians remain ill informed about the various legal rules and principles that impact the use of CTOs. It became clear that this state of affairs is seriously impacting the use of CTOs by dissuading physicians from using CTOs in cases where they could do so. Perhaps more importantly, the lack of basic knowledge about CTOs that we discovered in some quarters prevents physicians, particularly physicians in small centres and in the community, from using CTOs when they might be appropriate.

Our informants also spoke consistently about the need for reliable clinical education relating to CTOs. The feeling is that presentations by experienced clinicians with extensive CTO experience would encourage physicians to use CTOs when appropriate, particularly if they can be persuaded that CTOs are a manageable, effective treatment.

We also heard that the initial outreach and education done with regards to the CTO program did not reach the then provincial psychiatric hospitals with any degree of intensity. Whether this was an oversight or a deliberate choice is not clear. What is clear, however, is that the provincial hospitals and the former provincial hospitals tend to use CTOs somewhat less than other psychiatric facilities. It would appear that this phenomenon is attributable, at least in part, to this oversight or choice.

The lack of consistent and accurate knowledge with regard to CTO-related issues extends to consumers, families and the community at large.

5.23 The Use of CTOs Outside of Schedule 1 Psychiatric Facilities and ACT Teams

It appears that physicians operating outside of the framework of an ACT team or a Schedule 1 psychiatric facility have issued very few community treatment orders. In a few areas, family physicians have attempted CTOs on their own but it appears that a number of these physicians have abandoned the practice as unworkable.

We were told that family physicians find the initial organization of a CTO, even with the assistance of a CTO coordinator, to be far too onerous to undertake outside of an organizational framework, and that the ongoing task of managing a CTO has proven to be too much for the sole practitioner. We heard that there is a lack of support for sole practitioners attempting to deal with complex mental health issues and that case management and other essential resources are often lacking in the areas where one might expect family physicians to use CTOs.

We also heard repeatedly that the general shortage of family physicians makes it impossible in many areas across the province to find a family physician with the time to deal with CTOs and related issues.

5.24 The Problem of Police Checks

It became clear in the course of our consultations that work, paid or volunteer, is often a crucial element for the success of CTO clients in the community. Many of these positions require a police certificate to confirm the applicant does not have a criminal record. We heard that in many parts of the province, notably in the Toronto area, these reports go well beyond the requested information to indicate whether or not the requester has a criminal record and that they disclose other police interactions with the subject. The report may disclose, for example, if the police attended on the person to deal with an apparent suicide attempt or apprehension under the *Mental Health Act*.

We heard that the result of these reports might be that, although the person does not have a criminal record, he or she will not succeed in obtaining the requested position. This will occur either because the person is embarrassed to submit the report as provided or because prejudice against those suffering from mental illness will result in the offer of a position being withdrawn. The extraneous information may also result in an uncomfortable ongoing work environment. At the very least, the individual will have to disclose, for no apparent purpose, the sort of personal information that other members of society are entitled to assume will not be shared with anyone without consent.

5.25 Wellness

We heard from a number of sources, including consumers and consumer advocates, that it is well understood in the mental health field that wellness should be the goal of a good treatment plan. In other words, it is not sufficient just to address psychosis and other symptoms through medication and other treatment strategies. The individual must be provided with the resources and assistance that he or she needs to become a functioning, productive member of society with a self-defined satisfying and ongoing quality of life.

The point was put to us that this must involve far more than the achievement of treatment compliance and the measure of such things as a reduction in readmission rates, as important as these factors might be. This often requires a sophisticated multi-disciplinary approach with a multiplicity of services and supports available so that a tailored plan can be developed to serve and support the client while fostering their feelings of autonomy and well being.

It should also be noted, however, that we also heard from a number of psychiatrists that the primary goal of a CTO is compliance with medication and that this issue is properly the focus of successful treatment in the community.

5.26 Housing, Employment and Other Community Supports

A small number of physicians told us that the fundamental purpose of a community treatment order is to ensure compliance with medication and that other factors are not important. The vast majority of those with whom we

spoke agreed, however, that success depends on far more than medication. There was, in fact, a general consensus that successful treatment and ultimate wellness depend on the availability of a myriad of supports to the client. We heard that a fundamental purpose of a CTO and the case management that accompanies it is to link the client with the various services that he or she needs.

We were told that the nature of the required services varies with the client but often includes affordable and decent housing, employment or volunteer engagement, income support, social activities and contacts, ongoing consistent case management at an appropriate level for the client, peer support, and other services such as educational opportunities, management of general health, etc. A strategy that is designed to link the client with appropriate services is doomed to failure if those services are not available in the community or the client lacks access to them.

We visited some communities that told us that their housing resources and other services are adequate to meet the needs of their clients. We heard in many more places, however, that housing was either not available or grossly substandard or overpriced. We were told in many areas that case management at a level required by the client was not available and that second best would have to do. We visited several areas where the case management provided as part of the CTO arrangements would be continued until another arrangement could be made. We visited other areas, however, where the client loses his service upon the expiry of the CTO and was then expected to wait in excess of eight to ten months for other services.

In summary, many of the stakeholders with whom we met, professionals, families and consumers, told us that community treatment orders can only truly succeed in changing lives for the better if the necessary services are available in the client's community. Many people told us that these services are woefully inadequate in many areas of the province.

5.27 Leaves of Absence

Prior to the package of amendments to the *Mental Health Act* that came into effect on December 1, 2000 a leave of absence could only be issued by the officer in charge of a scheduled facility and only if it was intended that the patient return to the facility at the end of the leave. Substantial amendments to these provisions were included in the amendments. Section 27 of the act, which deals with leaves of absence, now reads as follows:

> 27. (1) The attending physician may, subject to subsection (3), place a patient on a leave of absence from the psychiatric facility for a designated period of not more than three months if the intention is that the patient shall return to the facility.
> Same
> (2) The officer in charge may, upon the advice of the attending physician, place a patient on a leave of absence from the psychiatric facility for a designated period of not more than three months.
> Terms and conditions
> (3) The attending physician and the patient shall comply with such terms and conditions for the leave of absence as the officer in charge may prescribe.
> Exception
> (4) This section does not authorize the placing of a patient on a leave of absence where he or she is subject to detention otherwise than under this act.

As can be seen from the section, the act now allows two types of leaves of absence. The first type is issued by the attending physician and may only be used if it is intended that the patient return to the facility at end of the leave. The second type does not require the intention that the patient return to the hospital at the end of the leave and may only be issued by the officer in charge of the facility. Both types of leaves may be issued for period of up to three months and are renewable. In all cases, patients and attending physicians are required to comply with any terms and conditions imposed on the leave of absence by the officer in charge.

Leaves of absence differ from CTOs in a number of fundamental ways. Unlike CTOs, no consent is required for a Leave of Absence. There is also no specific right to appeal a LOA to the Consent and Capacity Board although, in practice, virtually all LOA clients will be either involuntary or informal patients and will, therefore, be entitled to have that status reviewed by the board. A decision by the board to revoke the involuntary or informal status would theoretically leave the LOA intact, but would render it unenforceable since the ability to forcibly return the patient to the hospital would no longer exist.

These amendments were clearly designed to permit leaves of absence that could be used by attending physicians for routine matters, such as weekend or holiday passes, while creating a more substantial instrument requiring the signature of the officer in charge which could be used in certain circumstances in place of a community treatment order.

As we travelled across the province, a consistent picture developed with regards to leaves of absence. Almost no physicians or other health or helping professionals were aware of the amendments. Participants could not recall any education, information, guidance, or outreach having been provided. The use of leaves of absence was generally limited to weekend or holiday passes. Participants reported that no consideration had ever been given to using the more powerful Leave of Absence that can be issued by the officer in charge.

We also heard consistently that two problems, in addition to a lack of education and awareness, contributed to the failure to utilize this instrument. In fact, we heard that the use of leaves of absence had fallen out of favour over the years primarily as the result of these problems. The first issue is that staff members at most hospitals are under the impression that a bed has to be kept open for each patient released on a Leave of Absence. Hospitals do not, of course, have the capacity to do this. The second issue relates to the government's welfare policies. Specifically, health and helping professionals told us repeatedly and consistently that ODSP (the Ontario Disability Support Plan) considers patients in the community on a Leave of Absence as inpatients at a psychiatric facility and, therefore, discontinues their payments after a short period of time in the community. Officials at the ODSP head office told us that this is, in fact not the case. Under current ODSP rules, a person released into the community on a Leave of Absence is not to be denied ODSP on that basis. Since the majority of this population receives income support, the effective use of leaves of absence will continue to be untenable until the true state of ODSP policy is widely known amongst mental health providers.

We were also told by a few participants that leaves of absence cannot replace community treatment orders because they lack the discipline of a formal plan of treatment with assigned roles and responsibilities that exists with a community treatment plan.

In contrast to what we heard in almost all parts of the province, we spoke with a psychiatrist at one Toronto hospital who told us that psychiatrists at his facility are very familiar with the amended leave of absence provisions and that they use them as they deem appropriate. He also told us that he and his colleagues attempt to minimize the use of LOAs as they believe them to be more restrictive than CTOs given the fact that there is no appeal from a LOA.

5.28 Consent and Capacity Board Matters

Dissatisfaction with the legal review process was raised at most of our sessions with health and helping professionals. Only the issue of CTO enforcement was raised as consistently as we moved across the province. The vast majority of professionals with whom we spoke made it very clear that problems with the process and a desire to avoid it was a major factor in dissuading physicians from issuing and renewing community treatment orders.

Many physicians were unhappy with the way that they perceived themselves to be treated by the Consent and Capacity Board prior to the hearing. They reported last minute scheduling requiring them to rearrange already busy schedules one or two days before the hearing and a general sense of disorganization. The primary concern, however, was with the conduct of the hearings. Numerous physicians complained of lengthy hearings with a great deal of time devoted to procedural and technical issues.

Physicians complained that board members did nothing to protect them from belligerent and aggressive lawyers appearing on behalf of patients. Some physicians told us that they had been previously willing to participate in board hearings but that their attitude had changed as the result of the manner in which hearings were conducted. Many physicians were concerned that they are forced to attend increasingly complex and adversarial hearings without the benefit of legal counsel. The number of adjournments that they experience at the CCB also troubled many physicians and other professionals with whom we spoke. They told us that many of these are the result of the panel convening and then adjourning after ordering counsel for the patient.

A number of things became clear from our discussions with physicians with regards to the board. The physicians were dissatisfied in general with their contact with the board and most did not differentiate in this regard between CTO hearings and other matters that brought them in contact with the tribunal. This general high level of

dissatisfaction was highly influential in persuading them to conduct themselves in a manner that was likely not to bring them in contact with the board. This often included avoiding CTOs and avoiding second renewals of CTOs that result in a mandatory hearing before the board. It also became clear that many physicians formed their attitude with regards to the board based on what they had heard from colleagues rather than their own experience.

Numerous health and helping professionals across the province told us that it was their belief that many of the physicians in their facility or in their area avoided CTOs in general and second renewals in particular as the result of their dissatisfaction with the Consent and Capacity Board.

It is interesting to note that, while most of the physicians with whom we spoke believed that the problem with the Consent and Capacity Board was ongoing, some informed us that the problems seemed to be abating in the last year. One lawyer with a great deal of experience representing physicians before the board told us that the issues of technically complex and overly long hearings has significantly abated since the fall of 2004.

Many physicians told us that they believe that physicians would be more comfortable with the process if they had legal or paralegal assistance. We were told that some hospitals refuse to consider representation for their physicians. Some chiefs of psychiatry have attempted to provide legal assistance for hearings but have been told by their hospital administrators to fund their legal costs out of their departmental clinical budgets, thus forcing them to balance the need for legal assistance against other pressures such as the need for nursing staff.

Several of the board members with whom we spoke felt that it would be advantageous to provide physicians and others appearing before the board with easy access to summary legal advice so that they would feel less frightened and be more prepared. Board members were also of the view that the Psychiatric Patient Advocate Office could make a significant contribution towards easing the problem of late notice of hearings and adjournments if two changes were made. Firstly, they felt that rights advisers should be directed to provide physicians or hospital staff with a copy of the patient's application to the board so that physicians and hospital staff will have more time to prepare for hearings and clear their schedule instead of being caught off guard when contacted by the board to schedule a hearing. Secondly, they were of the view that the rights advisers should be required to inform the board when it is likely that a patient will be unrepresented before the board on a CTO matter so that the board has the option of ordering counsel as a preliminary step rather than doing so after the hearing has convened.

A number of board members were also of the view that two substantive changes to the law would expedite hearings and lower frustration levels without compromising rights. The first of these is changing the requirement that CTO clients meet the prerequisites for a Form 1. Members felt that this requirement should be replaced with a more flexible standard to the effect that the client is likely to become eligible for a Form 1A in the near future if not maintained on a CTO. The second recommended change relates to the requirement that consent must have been obtained in accordance with the *Health Care Consent Act*. This requirement does not exist in any of the other areas of the board's jurisdiction and opens up the possibility of lengthy and complex hearings that explore every element of the consent process.

Several board members and officials told us that the length of CTO hearings has dropped substantially over the past year. We were also told that they believe that the board has become much better at controlling its own process and limiting the time consumed with procedural matters.

5.29 Serving the Neediest Clients

Many participants told us that CTOs are an excellent way to serve many individuals suffering from serious mental disorders, but that they are not suitable for the neediest of clients. We heard for example, that they are not suitable for those who also suffer from serious drug abuse issues. We also heard that they are not ideal for those clients who are the most resistive to treatment or guidance.

A number of professionals informed us that CTOs are generally inappropriate for individuals who enjoy being admitted to hospital or, at a minimum, do not mind hospitalization. It was explained to us that the main incentive that a CTO provides for encouraging compliance is the fear of rehospitalization but that this is not effective for individuals who are not adverse to this prospect.

We heard divergent opinions on how the neediest clients might be served. Some professionals told us that strengthened enforcement provisions would be of assistance. Several felt that a totally different approach with

tighter and different control mechanisms might work. A large number of professionals with whom we spoke were of the view that CTOs or other variations on outpatient committal are most suitable to the client who is inclined to follow rules and the disorganized but directable client, but that they are not suitable for the highly resistive or complex client.

It became clear, however, that the principal reason that CTOs are not generally used with the neediest and most difficult of clients is that many mental health professionals and services do not provide services for them, and are arguably not inclined or equipped to do so. They prefer to direct their efforts and resources to clients who are more easily served. It was explained to us by a number of professionals that general hospital mental health units are not suited to the very high needs patient and that, with the divestment of the provincial psychiatric hospitals and the closure of beds, it has become increasingly difficult to find treatment for these individuals.

Whatever the reason for this phenomenon, we heard consistently that many quite ill individuals do not receive assistance from the formal mental health system. Many of these individuals have no OHIP card, no drug card, no fixed address and no psychiatrist. Many of them move from city to city. Many are in frequent contact with police and the courts as the result of small nuisance type offences. Some are never brought to trial because of the minor nature of their offence. Others are incarcerated for varying periods and ultimately released back into the community without being connected to the formal mental health system.

We were told that even where there is an easy way to link these individuals to the system, they would not be candidates for a community treatment order because they have neither the required track record nor the period of hospitalization. We also heard about rural and Aboriginal residents of the province who suffer from major mental health issues but who are not connected to a Schedule 1 facility and, in any case, also lack the required period of hospitalization.

5.30 Young People

A number of the people with whom we spoke raised the issue of young people experiencing their first psychotic episode. We were told that there is a considerable amount of research to indicate that vigorous intervention during the early stages of a psychotic disorder has proven itself to be particularly effective. Notwithstanding the proven efficaciousness of early intervention, we were told that CTOs are not available because of the requirement for prior beneficial treatment and previous hospitalization. We were urged by many of our informants to recommend changes that would remedy this situation.

It should be pointed out that this view was not unanimous. Several psychiatrists with whom we spoke believe that the existing rules generally allow intervention early enough on in the disease process to efficiently address the issue.

We talked to an expert who felt that CTOs were not suitable for dealing with adolescents. It was felt that there are so many legal controls over members of this age group that another one was not needed and would be unfair. It was also stated that an approach designed to exercise considerable control over the individual and their treatment, based on the expectation that past clinical and behavioural patterns would repeat themselves, was not appropriate given the fluidity that typifies members of this age group.

6.0 Written Submissions

On our website and in our conversations and correspondence with representatives of various organizations, we made it clear that we were open to receiving submissions on behalf of organizations.

In response to this request, we received letters outlining concerns and/or issues, copies of studies that had not been published, and data from many organizations. In some instances, representatives of an organization preferred to speak informally about CTOs.

In order to comply with requests to maintain confidentiality, we have included the comments in section 5 with the reports on our interviews. The data and studies have been incorporated in section 4.

7.0 Findings

7.1 The Reasons that CTOs Were or Were Not Used During the Review Period

There is no data on the reasons that CTOs were used or not used. Also, this is a topic that is not definitively addressed in the literature. We, therefore, had to rely on the results of our interviews in order to answer these questions.

7.1.1 What Factors Affect Clients' Decisions to Use/Accept a CTO?

CTO clients or potential clients tended to have very specific reasons why they found a CTO acceptable or unacceptable.

7.1.1.1 Clients' reasons for using/accepting

- **Support to get over the rough spots**
  Some consumers see CTOs as a way of ensuring their treatment during periods of diminished insight in which they can become non-compliant with treatment and suffer serious consequences as a result.
- **Access to services**
  Some consumers believe that a CTO will provide access to services such as housing and case management.
- **Pressure from health providers**
  Many consumers agree to sign a CTO after being given the impression that their consent is the price of discharge from the hospital.
- **Incapable acquiescence**
  It would appear that some consumers are not in a state to make any capable informed decision at the time of signature but sign because of the various pressures brought to bear upon them.
- **Desire to avoid future hospitalization**
  Many consumers believe that a CTO will help them avoid a return to a previous state of illness and future rehospitalizations.
- **Satisfaction with a previous CTO**
  Many consumers agree to a renewal or reissue as the result of their appreciation of gains made or services provided on a previous CTO. This is often based on services provided but may also reflect appreciation of their improved health, stability, and social reintegration.

7.1.1.2 Clients' reasons for not using/accepting

- **Lack of insight**
  Some consumers of questionable decisional capacity lack the insight to appreciate their situation and, therefore, refuse to consent to the CTO.
- **Concerns with autonomy and dignity**
  Some consumers find the control over them and the status of being on a CTO as demeaning or otherwise troubling. Some believe that a CTO implies that they are dangerous or even criminal.
- **Dissatisfaction with a substitute decision-maker**
  Some consumers are not happy with the substitute decision-maker that has been identified for them.
- **Graduation**
  Many consumers do not continue with the CTO because of their belief that they have already derived maximum benefit from the program and are ready to move on.

7.1.2 What Factors Affect Physicians' Decisions to Use/Accept a CTO?

The reasons that physicians use or do not use CTOs are complex and inter-related. They vary from physician to physician and between jurisdictions, especially as the rules for CTOs differ between jurisdictions. Some factors, depending on specifics, may provide either encouragement or dissuasion. Factors range from the philosophical or ideological to the very practical. The major factors that we have identified through our interviews follow.

7.1.2.1 Physicians' reasons for using/accepting

- **Belief in the righteousness of CTOs**
  Some psychiatrists are firmly committed to the concept of outpatient committal. These clinicians believe that the clinical benefits of CTOs far outweigh any intrusion into the rights of their patients. Many believe that CTOs protect the rights of their patients by keeping them out of hospital and promoting wellness and reintegration. Others believe that CTOs are important in respecting families, easing their burdens, and bringing them into the circle of care.

- **Belief in the efficacy of CTOs**
  Not surprisingly, psychiatrists who use CTOs tend to be those who believe in the concept and effectiveness. In many cases, they have had positive experience with previous CTOs and believe that they are useful.

- **Organizational resources**
  CTOs are being used almost exclusively by psychiatrists who are members of the staff of an organization with good links to community resources. Utilization appears to increase if the CTO coordinator and representatives of the community agencies are part of the discharge planning process.

- **Family insistence**
  In some cases, family members of the patient are aware of the legislation and actively and successfully lobby the health professionals to place their loved one on a CTO.

- **Access to resources**
  We believe that access to scarce resources including case management is often a prime motivator for physicians who place their patients on a CTO.

- **Encouragement and mentoring**
  Utilization tends to increase significantly in those facilities where the chief of psychiatry or a program manager has taken a personal interest in CTOs or where a single psychiatrist has taken the lead with regards to CTOs.

- **The availability and assistance of the CTO coordinator**
  We heard from many psychiatrists that the assistance of the CTO coordinator and the presence of the coordinator on-site at the hospital makes it much more likely that they will use CTOs.

- **Salaried physicians**
  As noted, below, CTOs can be labour-intensive and less remunerative for fee-for-service psychiatrists than other activities. A number of salaried psychiatrists told us that that they would not be in a position to utilize CTOs were it not for the fact that they are not paid on a fee-for-service basis.

7.1.2.2 Physicians' reasons for not using/accepting

It should be noted that psychiatrists who are not using CTOs were much less willing to speak with us than psychiatrists who do. While this is clearly a limiting factor in our work, we believe that we have gained a reliable picture of the reasons that psychiatrists may shy away from using CTOs. The main reasons provided are as follows:

- **Concerns with the enforcement process**
  This issue was one of the two that was most often raised with us. A large majority of the psychiatrists and other health and helping professionals with whom we spoke believe that the enforcement process is profoundly flawed. Some believe that the problem is so serious that it makes CTOs of little value. One perceived problem is with the apprehension process. Under certain defined circumstances, a physician may issue what is known as an Order for Examination or Form 47, which authorizes the police to apprehend the client and bring him or her to the issuing physician for examination. If appropriate and legally justified, the physician may sign a Form 1 after this examination. The Form 1 authorizes detention for a period of up to 72 hours for the purpose of assessing

certifiability. The concerns expressed with regards to this process may be summarized as follows:

- The act specifies that the patient be brought to the clinician or a designate rather than any Schedule 1 psychiatric facility. This is seen as unworkable and an imposition on the physicians in question. It also seen as unworkable if the patient is a long distance from the signing physician. It can also create friction with or resistance on the part of police who must occasionally transport patients over long distances.
- The act has been interpreted by many, including the Consent and Capacity Board, to mean that the community treatment order is voided once a patient is apprehended on a Form 47. This means that the entire CTO process must begin again after an individual is apprehended on a Form 47, failing which the individual will cease to be on a CTO.

These issues, particularly the latter, have convinced some psychiatrists to either stop using CTOs or, at least, to reduce the circumstances in which they will use them.

- **Disillusionment with the Consent and Capacity Board**
  Disillusionment with the Consent and Capacity Board and its process was consistently raised either as the most important issue, or as one of the most important issues, as we moved across the province. It was clear that a sizeable number of clinicians are willing to take whatever steps are necessary to avoid interacting with the board. Members of another large group are highly influenced by their desire not to appear before the board to the extent that this significantly affects their conduct and decision-making with regards to their patients.

  While a small number of clinicians are disturbed specifically by the board's performance with regards to CTOs, the large majority do not distinguish between the board's performance with regards to CTOs and its general performance in all areas. It also became clear very quickly that the increasingly hardening attitudes of psychiatrists with regards to the board are influenced as much, if not more, by what they hear from colleagues than by their own interactions with the board.

  The concerns expressed to us relate to both the administrative and adjudicative functions of the board. We heard that hearings are usually scheduled one or two days before the hearing, forcing clinicians to cancel patients and rearrange their days at the last moment. We heard that hearings are frequently adjourned to a new date, often as the result of the panel's decision to order legal counsel for the patient, forcing the clinician to set aside yet another day for the hearing. We were told that hearings have become increasing adversarial and that panel members frequently do not intervene when patients' legal counsel engage in what the psychiatrists perceive as abusive conduct towards them.

  Psychiatrists are also concerned about the effect that a hearing, particularly a difficult, long and overly adversarial hearing, will have on their patients. We were also told that hearings are getting longer and longer and that the nature of the inquiry frequently focuses on what the clinicians perceive to be irrelevant and often indecipherable technical matters. A significant number of clinicians are of the view that they should be provided with legal representation before the board. It should be noted that one well informed source told us that the focus on technicalities and the problem with lengthy hearings abated to a very significant degree in the fall of 2004. However, this change, if it occurred, has not affected psychiatrists' opinions of the board and its process as far as we could ascertain.

  All of this has resulted in there being a large number of physicians who simply refuse to become involved with CTOs. Another sizeable group is made up of psychiatrists who are not willing to make findings of incapacity. As a result, they will only become involved in a CTO if the patient is willing to consent to the community treatment plan. It was our impression that most members of this group are in the habit of ignoring the requirement for capable consent and have replaced it with simple acquiescence. In other words, a patient's willingness to sign the community treatment plan will be accepted without regard to the patient's decisional capacity.

  On the other hand, a patient's refusal to sign will signal the end of the matter, again, without consideration of legal capacity. This situation results in both the consent of legally incapable patients being improperly accepted and the denial of service to non-acquiescent legally incapable patients. We also heard from clinicians in many parts of the province, that CTOs are not continued beyond the first renewal because of the extreme reticence of the psychiatrists to face the mandatory hearing that must take place on the occasion of the second renewal.

- **The requirement that the patient meet the Form 1 criteria**
  A patient who is not in the hospital only qualifies for a CTO if he or she meets the criteria for apprehension under a Form 1 (Application by Physician for Psychiatric Assessment). A patient who has been deemed to be incapable of consent to treatment could meet the Box A (dangerousness) grounds or the Box B (need for treatment) grounds of the Form 1. A capable patient who is outside of the hospital, however, will only meet the criteria for a CTO if he or she meets the dangerous criteria of a Form 1. Because the Form 1 dangerousness criteria arguably require a certain degree of immediacy, there is a wide consensus among psychiatrists that a CTO may only be renewed for a capable client if the previous CTO has failed. The argument is that the client will not meet the criteria if the CTO has been a success. These psychiatrists would argue that they are in the position of having a clinical treatment modality whose continued use with a patient is only authorized if it has proven itself to be a failure. They also point out that this problem only arises with capable patients who must, in any event, consent to the CTO if it is to be continued. In other words, the successful CTO may not be renewed for a capable patient even if the psychiatrist and the patient are in agreement that it should be renewed.
- **A perceived "lack of teeth"**
  In the course of our consultations, we heard again and again from a significant minority of health and helping professionals with whom we spoke that the legislation "does not have any teeth." When asked for further particulars we were generally told that the legislation is of little use because it does not allow for forced medication of patients. A few of these individuals would like the authority to force medication in community settings. The majority of these psychiatrists, however, would prefer a provision allowing short-term apprehension so that medication could be administered at the hospital. It should be noted that many psychiatrists and other health and helping professionals do not believe that a provision allowing forced treatment is necessary or even advisable. It should also be noted that this issue is closely tied to the enforcement issue noted above.
- **Concerns with the complexity and amount of time required to institute a CTO**
  Numerous psychiatrists are either unwilling or reticent to use CTOs because of the length of the process, the amount of paperwork involved, and the amount of time that is consumed in the process. Interestingly, a number of psychiatrists, upon reflection, conceded that it is the CTO coordinators, not the psychiatrists who are responsible for the paperwork in question and that the process is, in fact quite easy for the psychiatrist. The concerns with the paper load relate to both the amount of work involved and the multiplicity of steps and forms that are required to initiate a CTO. There is also a great deal of resentment around the fact that the entire process must be repeated every six months if the CTO is to be renewed.
- **Dearth of suitable candidates**
  Some clinicians view CTOs as an instrument of almost universal applicability. A sizeable proportion of clinicians is, however, of the view that CTOs, by their very nature, are instruments that are effective only with certain patients. Many of them told us that CTOs are of particular use with clients who are inclined to follow rules or those who will benefit from the introduction of order into their lives. Many of these clinicians are of the view that factors such as substance abuse, anti-social personality traits, or general resistance to authority are contraindications for a CTO. It should be emphasized that this list is provided by way of example only as different clinicians have different views on who might, and who might not, benefit from a CTO.
- **Concerns regarding legal liability**
  A number of psychiatrists with whom we spoke are concerned with liability issues surrounding CTOs. While most are aware of the legal protections found in the act, they believe that there are other risks such as potential liability for the conduct of other professionals who are responsible for parts of the treatment plan but not directly affiliated with the psychiatrist's hospital.
- **A belief that CTOs are or may be a violation of the rights of their patients**
  We spoke with a number of psychiatrists who do not use CTOs or who keep their involvement to a minimum because of their serious reservations as to the ethical propriety of CTOs and a belief that CTOs are an unnecessary infringement of patients' rights.
- **A belief that CTOs are redundant**
  A number of psychiatrists, particularly those working in the community told us that CTOs add little to the range of treatment modalities available to them. These psychiatrists believe that assertive community treatment and other community services such as housing, taken together with personal relationships that can be developed with patients over time, in addition to their ability to use the other apprehension provisions in the *Mental Health Act* provide the complete array of treatment modalities that they need. Other psychiatrists believe that more are required, but that CTOs as currently formulated add nothing to their other powers and authority.

- **Concerns for the therapeutic alliance**
  Some psychiatrists, particularly those who work in community settings, shy away from CTOs because of a belief that introducing compulsion to the relationship will harm the trusting relationship between the patient and the physician.

- **Lack of resources**
  In certain parts of the province, including some rural and northern areas, clinicians shy away from using CTOs in certain circumstances because of a lack of resources such as case management, housing, or other supports.

- **Lack of support for community physicians**
  Sole practitioners, whether they are family physicians or psychiatrists, have not been using CTOs in any great number. Some have attempted to institute a CTO only to abandon it, and future CTOs as unworkable. The situation is somewhat different when the practitioner is provided with extensive backup and support. When strong linkages are established between the hospital or other specialized agency and remote practitioners, including accessible expertise and other supports, CTO use tends to increase.

- **A belief that more money can be earned doing other things**
  There is view among psychiatrists who put a high priority on income maximization that more money is to be earned elsewhere. We were told that the OHIP claim forms for CTOs are so complex and time consuming that many psychiatrists either use a somewhat less remunerative billing code, or don't bill at all for CTO-related work. We also heard that much of the CTO work, such as telephone calls and paperwork, is totally unremunerated. We should note, however, that we were told during the course of our visits to some locations that the sessional funds allocated by the government for CTO purposes has been used successfully to compensate physicians for this sort of work.

- **Lack of mentoring and encouragement**
  CTOs are a relatively new instrument. They require the clinician to conduct him or herself in a new way. They require new and somewhat complex interpersonal relationships and assured access to community services. They also require access to inpatient beds when required and, possibly, a somewhat lengthened stay in preparation for the CTO. All of these elements require institutional support and planning as well as expertise and mentoring on the part of the chief of psychiatry or another designated senior staff member. Staff members who lack this institutional support and personal leadership are far less inclined to use CTOs.

- **The length of CTOs**
  A sizeable number of psychiatrists are of the view that the six-month duration of CTOs is too short. Many of them are concerned with the necessity to repeat the labour-intensive CTO initiation process every six months. Many are also of the view that the six-month period is too short for clinical progress to appear and solidify given the fact that the disease process being treated has frequently been in placed, often unchecked, for many years.

- **Lack of knowledge and familiarity**
  Many physicians are uncomfortable with CTOs because they have not received sufficient education in their use and they lack experience with regards to CTOs.

- **The requirement for prior hospitalization**
  A number of criticisms were levelled at the requirement for prior hospitalization. Some of these are as follows:
  - The criterion, we were told by some, limits usefulness with regard to those suffering from their first psychotic episode. (It should be noted that others disagreed, expressing the opinion that the criteria are met early enough in the illness to be satisfactory.)
  - We were told that it also prevents the use of CTOs for individuals who would meet the test were it not for the fact that their recent treatment or institutionalization had been in a prison or non-Schedule 1 facility rather than in a Schedule 1 facility.
  - In some parts of the province members of the aboriginal community suffering from serious and persistent mental illness are less likely than other Ontario residents to seek out or receive inpatient care.

- **Lack of a belief in the efficacy of CTOs**
  Some physicians are of the belief that CTOs add little to the arsenal that they already possess. Some of these individuals base this belief on dissatisfaction with the current legislation while others hold that view with regards to outpatient committal in general.

- **Inertia**
  In some places, CTOs are not in use or not in wide use simply because the time and effort has not been invested in bringing about the changes in practice and organization that would be required to utilize them.

- **Mythology surrounding the Starson Case**
  In the Starson case, the Supreme Court of Canada made a fact-specific decision regarding a particular patient. In the course of that decision, the court upheld the Ontario legislation while reaffirming the necessity for its objective and dispassionate application. Notwithstanding the fact that the court expressed support for the status quo and did not change the legislation or the way that it is to be applied, an unfortunate level of mythology has grown up around the case. A number of physicians are labouring under the misapprehension that the court changed the law or set new standards for capacity. This view, while not based in reality, is dissuading some clinicians from becoming involved with CTOs.

- **Capable clients refusing consent**
  Some individuals who have been identified as both good candidates for CTOs and capable of consenting to treatment, have refused to enter into the community treatment plan

- **Client discharge prior to CTO being put in place**
  There is a considerable amount of pressure to discharge patients from hospital. We were told that this results in potential CTO clients often being discharged prior to the CTO being in place, or being sent home with a CTO but before the program supports required for the CTO to succeed being made available to the client.

- **Lack of access to physician for community follow-up**
  We were told that in some parts of the province CTOs are not a workable proposition because of the lack of family physicians to provide the necessary supervision and follow-up.

- **More remunerative ways of spending their time**
  We were led to understand that a certain portion of the profession avoids CTOs because they are viewed as not sufficiently remunerative. For some, the issue is that some of the CTO responsibilities, such as telephone calls, are not remunerated. For others, the view is that, from an income maximization standpoint, CTOs are not at the top of the list.

- **Success**
  CTOs are sometimes not renewed because the physician is of the view that maximum benefit has been derived and the client is likely to continue his or her success without the further need for a CTO.

- **Failure**
  CTOs are sometimes not renewed because the previous CTO has failed to deliver the expected benefit for the client.

7.1.3 What Factors Affect Substitute Decision-makers' Decisions to Use/Accept a CTO?

7.1.3.1 Substitute decision-makers' reasons for using/accepting

- **Recommended by health care team**
  Some substitute decision-makers consented to a CTO because that course of action was recommended by the health care team that cared for their loved one and either they feel pressured to agree or they are the type of individual who is inclined to go along with professional recommendations without question.

- **Desperation**
  A number of family members told us that they have been struggling for years to find some care and attention for their loved one and that CTOs seem to be a way to do that.

- **A way of having input**
  Some family members see CTOs, particularly when they are the SDM, as a way of playing a role and exercising some leverage in the care of their loved one. Many of these individuals have felt powerless for considerable periods.

- **A way to exercise leverage**
  Many family members who have felt previously powerless in the face of the illness and the power of the professionals, appreciate the leverage over those professions that they wield with their power to consent or not consent.
- **Access to information**
  Some family members see a CTO with themselves as SDM as a way of getting access to information about the patient from which they have previously been excluded.
- **Expectation of success**
  Some family members are very familiar with the worldwide discussion of outpatient committal and believe the concept to be very promising for the loved one.
- **Success**
  Some family members have had an extremely positive experience with a previous CTO for their loved one and want to repeat or continue in that direction.

7.1.3.2 Substitute decision-makers' reasons for not using/accepting

- **Refusal of rights advice**
  Some family members have expressed a willingness to consent but have then refused to be available to meet with the rights adviser.
- **Affront to dignity**
  Some substitute decision-makers believe CTOs to be an affront to the dignity of the subject person.
- **Potential for harmed relationships**
  Some families are concerned that their consent to a CTO is likely to offend their ill relative and, thereby, lead to a rupture in their relationship with that person.
- **Cynicism**
  Many family members have experienced years of less than satisfactory results at the hands of the mental health system. As the result of this experience, some family members are not inclined to provide consent to a CTO because of a feeling that the system has failed their loved one, is inept, and is not likely to have anything of use to offer.
- **Difficulties with rights advice**
  According to our information, on at least one occasion a substitute decision-maker has refused to consent after having received the impression from a representative of the Psychiatric Patient Advocate Office the he or she could be subject to serious legal liability for doing so. According to our information, consent was refused on another occasion after the Psychiatric Patient Advocate Office refused the request of a new Canadian who did not speak English to provide her with rights information in written form. While the PPAO will arrange and pay for interpreters in any language, it does not have the capacity to provide written materials in all languages.

7.1.3.3 Other important decision-making factors

- **Decision-making rules**
  A community treatment plan is defined as a treatment under the *Health Care Consent Act*. Sophisticated and/or properly instructed decision-makers are aware of their legal responsibility to make decisions according to the decision-making rules found in section 21 of the act. Those rules require the SDM to comply with a prior capable wish if the wish was made when the patient was capable and at least sixteen years of age, is the patient's most recent capable wish and is not impossible to comply with.
- **Client willingness and ability to comply**
  The decision of the substitute decision-maker is sometimes based on his or her perception of the willingness and ability of the client to cooperate and comply with the plan and the order.
- **Ongoing role of the substitute decision-maker**
  Some substitute decision-makers base their decision, in whole or in part, on their desire or unwillingness, as the case may be, to assume responsibility and authority under the Community Treatment Plan.

- **Availability of resources**
  Substitute decisions are sometimes made on the basis of the decision-makers' perception of the availability of resources such as housing and support workers that the client needs to succeed.

7.1.4 What Alternatives to CTOs are Being Used to Manage Clients in the Community?

Assertive Community Treatment Teams (ACTT) and other forms of comprehensive case management in the community are the most common community alternative to CTOs. In fact, we were consistently told that CTOs are frequently used as a fallback in areas where ACT Teams are non-existent or whose caseloads are full.

CTOs may be seen as unnecessary in areas where satisfactory levels of service are combined with a highly developed working relationship between the hospital and the community providing clients with seamless care as they move between the hospital and the community.

Clients who are not otherwise receiving appropriate care in the community may end up in the criminal justice system where their care, if any, will eventually be provided in correction institutions or in the community under the supervision of the probation and parole services or the Ontario Review Board.

Numerous individuals in the community reach a degree of stability and wellness with the assistance of one or more of the community mental health agencies that form a rich mosaic of services and service philosophies across this province. Others find the help they need at various consumer-run businesses or agencies such as drop-in centres that provide peer support and a myriad of other services in a supportive and non-threatening environment.

7.1.5 What are the Characteristics of Clients Using CTOs?

There does not appear to be a wholly consistent profile of CTO clients across the province. There are, however, some common themes and similarities. All CTO clients must meet the criteria in subsection 33.1 (4) the *Mental Health Act*. They all, therefore, have a history of treatable mental illness, they all meet the hospitalization criteria of the act and they are all either hospitalized at the outset of their CTO or they meet the criteria for a Form 1.

An analysis of Ministry of Health and Long-Term Care (MOHLTC) data indicates that 54.3 per cent of CTO clients are male and 45.7 per cent are female. While a very small minority of CTO clients are young or elderly, approximately 70 per cent are aged 21 to 50. A similar percentage of CTO clients are diagnosed as suffering from schizophrenia and about 30 per cent suffer from schizoaffective disorder or bipolar disorder. Very few are diagnosed as suffering from a personality disorder, developmental disorder, or are seen as having a serious substance abuse problem.

Clients tend to have a long history of involvement with the mental health system. They also tend to be individuals who are seen as likely to comply with their CTO.

About half of CTO clients are considered to be capable of consenting to their own treatment and have, therefore, given consent on their own behalf to the treatment. As noted elsewhere in the report, this would appear to be at least partially explained by the propensity of some physicians to accept acquiescence as equivalent to capable informed consent and their reticence or refusal to make findings of incapacity or issue a CTO for a patient who has been found incapable. The percentage of capable patients varies widely from hospital to hospital with some hospitals using CTOs exclusively or almost exclusively with notionally capable patients.

In many cases, CTO clients are individuals who are considered not to be needy enough for ACT Teams admission or were unable to access ACT Teams or other case management services without a CTO.

Because of the requirement for hospitalization, the CTO client base excludes many individuals who might otherwise be considered suitable. This group includes those suffering from first episode psychosis, individuals who have been cared for in the community or institutionalized out of province, in correctional settings, non-Schedule 1 hospitals, children's treatment centres, or residential care settings. Also excluded are individuals suffering from serious and persistent mental illness and who are not connected to psychiatric services.

It would appear that the neediest individuals, those whose illness is the most severe, those who are the most resistant to care, or those not involved in the formal mental health system, are very unlikely to be put on a CTO. Those who are the most likely appear to be those who are at least somewhat directable or inclined to follow rules.

7.1.6 Where are CTOs Originating?

While some CTOs are originating with organizations such as ACT Teams, most are issued out of Schedule 1 psychiatric facilities.[17] A small number of family physicians[18] in the community have initiated CTOs but many of these experiments have been abandoned by their physicians as unworkable. Some have succeeded with the help of vigorous support from outreach teams located in Schedule 1 facilities. Some ACT Teams have initiated CTOs in the community but this practice, while often successful, does not appear to be widespread. It would appear that the low rate of initiation in other settings is attributable to the lack of physician manpower, the lack of payment incentives for physicians, the lack of resources, and the lack of sophisticated infrastructure and other supports that can be marshalled by an ACT Team or in a hospital. It should also be noted that philosophical opposition to CTOs is more prevalent among professionals working in community settings.

CTO usage in Schedule 1 facilities is uneven across the province. In some of these facilities CTOs are used routinely and in large numbers. In other facilities they are used rarely or not at all. Reasons for use and non-use vary from hospital to hospital. High use hospitals tend to have a chief of staff or other individual who is willing to promote CTO usage and mentor and support those psychiatrists who are willing to issue them.

Usage is also dependent on the availability of case management services and other resources in the community. A lack of these resources may discourage use if it results in an inability to support CTO clients in the community. A shortage may, however, actually encourage use if CTOs are seen as a way of accessing scarce resources. Conversely, an abundance of community resources may dampen the demand for CTOs if resources are readily available to clients who are not on a CTO.

The level of CTO usage is often profoundly influenced by the quality of the relationship between the hospital and agencies in the community. If a moderately close and comfortable working relationship exists or can be developed between the agencies and the hospital, CTOs are likely to be utilized. If the relationship is poor or non-existent, the likelihood of CTO use is significantly reduced. If the working relationship between community agencies is highly developed and resources are abundant, CTO usage may be deemed to be redundant and unnecessary.

CTO coordinators are crucial to the level of CTO usage in a hospital. It would appear that CTOs are more likely to be used in hospitals with an on-site CTO coordinator. Usage also appears to be improved if the coordinator and representatives of community agencies are regular attendees at hospital inpatient discharge planning meetings.

7.2 The Effectiveness of CTOs During the Review Period

7.2.1 What Effect do CTOs have on Client Well-being and Satisfaction?

Other than a small number of local Ontario studies that are referred to in section 4.4 of the report, there was no quantitative data available that addresses the issue of client well-being and satisfaction. Our review of the literature indicated that most studies concentrated on factors other than client well-being and satisfaction. However, one New Zealand interview study of Maori CTOs did indicate an improved perception of well-being and satisfaction.

The qualitative data that we have gathered through our interviews provides a strong indication that clients who have been placed on a community treatment order in Ontario have experienced substantial improvement in a number of spheres.

Many clients have reported to us that they believe that their CTO has brought them a level of stability and allowed them to stay outside of hospital. Clients, by and large, are very appreciative of the level of personal support and attention that they receive. Some have told us that the CTO kept them treated during periods of severely diminished insight. We have met clients who told us that their CTO has allowed them to find stable housing for the first time in years, completed their education, or reintegrate into the community after years of social isolation. It should be noted, however, that some clients felt that any benefits were outweighed by the loss of personal autonomy and control over their lives.

[17] See Table 7.
[18] See Table 2.

Family members, with some notable exceptions, have reported substantial improvement for their loved ones and a significant easing in the problems that the illness creates for the family and all of its members. We have heard of clients returning to school, once again becoming loving members of their families and stopping troubling behaviour such as repeated suicide attempts. The experience has not, however, been universal. One mother told us that her son's CTO had saved his life, as he had ceased his previous pattern of serious suicide attempts. Another parent, however, found the whole experience to be of little benefit to his son because of what he perceived as lack of attention on the part of caregivers. Many families are angry and frustrated that their loved ones have not been placed on CTOs.

Some of the mental health professionals with whom we spoke were disappointed with their experience with CTOs. Some had even decided not to continue with their use. It should be noted, however, that most of mental health professionals with whom we spoke and who have experience with CTOs believe them to be a highly effective instrument. These professionals are of the view that readmission and length of stay rates for their CTO clients have plummeted and their quality of life has improved.

7.2.2 What Services and Supports are CTO Clients Receiving?

The *MOHLTC Community Treatment Order (CTO) Information Record* database identifies a wide range of services that are to be received by each CTO client under their proposed community treatment plan. As indicated in section 4.4, these include, but are not limited to:

- Hospital outpatient psychiatry/mental health programs
- Assertive community treatment (ACT)
- Addiction service
- Crisis intervention
- Case management
- Private psychiatrist
- Medication management/clinic
- Supportive housing
- Non-psychiatric medical care
- Community mental health services through a specified agency
- Other services, e.g., physician for injections/depot injection clinic, court diversion, occupational therapy, counselling, forensic services, self-esteem/anger management, Public Guardian and Trustee or other trustee for finances, shelter while waiting for supportive housing.

The use of these services depends on the needs of the CTO client, the availability of the services in the community, and the relationship between the hospital initiating the CTO and the local community agencies.

7.2.3 What are the Factors Impacting on the Effectiveness of CTOs?

Our qualitative data leads us to conclude that CTO clients in Ontario have received substantial benefits from the program. What we are unable to determine, however, is what factors have contributed to that success. CTO clients are subject to substantial legal restrictions. They also receive a level of services, attention, and organization that is far above the norm for individuals in their position.

Most of the professionals with whom we spoke believe that the benefits noted for their clients are attributable, in large measure, to the increased coordination and level of services that these clients have received. Many spoke of the benefits of the perceived increased level of professional accountability and hospital/community co-operation that CTOs seem to produce. Some attributed the success primarily to the legal restraints placed on the patients; others felt it was a mix; while still others believe that the reasons for success vary from client to client.

We have concluded that a very large majority of CTO clients have derived substantial benefit from the experience. We are unable to conclude however, what, if any, of this benefit has derived from the legal restraints placed upon CTO clients as opposed to the services, increased professional accountability and level of professional organization devoted to their care.

These findings are consistent with the result of our literature review. It seems clear that the intangible outcomes of CTOs, such as client well-being and satisfaction, can only be measured through a carefully designed, focused study. More important, however, is that CTO coordinators, physicians and other service providers monitor the progress of individual CTO clients to determine whether or not the desired tangible and intangible outcomes are being achieved.

7.3 Methods Used to Evaluate the Outcome of any Treatment Used Under CTOs

7.3.1 What Client Outcomes are Being Measured?

The MOHLTC collects data on a CTO client's use of services during the six months before the current CTO, on the services to be involved in the current CTO, on a CTO client's involvement with the legal system during the six months before the current CTO, on who a CTO client lives with and the type of housing occupied by a CTO client. These are some of the factors that address client outcomes.

However, there is no systematic measuring of treatment outcomes for CTO clients, other than a support team's monitoring of an individual's progress in the normal course of treatment.

A few local studies have attempted to measure client outcomes. However, the number of subjects in each study is too small to draw Ontario-wide conclusions. These studies tend to measure client and family and health care provider satisfaction, as well as comparing such things as hospitalizations, legal involvement, type of housing, income and employment, etc. both before and after the CTO.

7.3.2 How are Client Outcomes Being Measured?

As mentioned in section 7.3.1, through its data collection activities, the MOHLTC has a limited view of client outcomes that is restricted to the services that they receive, their involvement with the legal system and their living arrangements.

In general, client outcomes are being measured on an individual basis through local data collection, and on a group basis through the use of file review and questionnaire/survey tools. There is no such measurement on an Ontario-wide basis.

7.4 Mechanisms and the Effectiveness for Provision of Rights Advice

Rights advice in Ontario has historically been mandated for patients in psychiatric facilities who are entitled to apply to the Consent and Capacity Board as the result of their involuntary status, a finding that they are incapable for the purpose of making treatment or financial decisions, or some other decision by their attending physician giving rise to a right to apply to the board. Rights advice is considered by many to be an essential component in the system of checks and balances necessary for protection of civil rights in the mental health field.

Traditionally, rights advice starts as a pure information giving process. If the patient then wishes to proceed to the board, the rights adviser assists with the application process and retention of a lawyer if the patient so desires. Objective, neutral, non-ideological rights advice has always been considered to be the hallmark of good service. It has always been considered critical to clearly separate rights advice from advocacy and legal advice.

Historically, rights advice has been provided through a number of vehicles. Until 1995, rights advice was provided in provincial psychiatric hospitals by rights advisers employed by the Psychiatric Patient Advocate Office (PPAO) and outside of those facilities by duty counsel lawyers retained by the Legal Aid. Between April 1995 and March 1996, the now defunct Advocacy Commission provided services. Since that time, both the PPAO and rights advisers trained by the PPAO but retained or employed by individual psychiatric facilities have provided rights advice. Over time, the PPAO has negotiated contractual arrangements with most of the Schedule 1 facilities in the province to provide rights advice although a few pockets of non-PPAO rights advice still exist.

As noted previously, the formulation of a CTO involves a number of steps. Rights advice must be provided between the time that the community treatment plan is proposed and the time that it is signed. An application to the board may only be made once the CTO has been issued. Rights advice must always be offered to a patient, although the patient is entitled to refuse to see the rights adviser. Rights advice must also be given to the substitute decision-maker, if any. A person who refuses to receive rights advice is not entitled to act as a substitute decision-maker. Although a small percentage of CTO rights advice is provided by non-PPAO rights advisers, that office provides almost all of the CTO rights advice in psychiatric facilities and all of the community CTO rights advice.

CTO rights advice is generally offered in person by rights advisers employed by or under contract to the PPAO. Occasionally rights advice for substitute decision-makers is provided by telephone. It would appear that resource, staffing, and logistical issues dictate this practice.

Subsection 1(1) of the *Mental Health Act* defines a rights adviser as follows:

> (1) "rights adviser" means a person, or a member of a category of persons, qualified to perform the functions of a rights adviser under this Act and designated by a psychiatric facility, the Minister or by the regulations to perform those functions, but does not include,
> (a) a person involved in the direct clinical care of the person to whom the rights advice is to be given, or
> (b) a person providing treatment or care and supervision under a community treatment plan;

Subsection 1(2) of the act defines "explain" in the context of rights advice as follows:

> (2) A rights adviser or other person whom this act requires to explain a matter satisfies that requirement by explaining the matter to the best of his or her ability and in a manner that addresses the special needs of the person receiving the explanation, whether that person understands it or not.

Subsection 33.1(4) of the act reads, in part, as follows:

> (4) A physician may issue or renew a community treatment order under this section if,
> (e) subject to subsection (5), the physician is satisfied that the person subject to the order and his or her substitute decision-maker, if any, have consulted with a rights adviser and have been advised of their legal rights;

Subsection 33.1(5) reads as follows:

> (5) Clause (4) (e) does not apply to the person subject to the order if the person himself or herself refuses to consult with a rights adviser and the rights adviser so informs the physician.

The regulations to the act contain the following provisions with regards to rights advice regarding community treatment orders:

> 14. (1) The Minister shall designate one or more persons or categories of persons to perform the functions of a rights adviser under the act in each psychiatric facility designated as an institution under the *Mental Hospitals Act* and may revoke such a designation.
> (2) A psychiatric facility that is not an institution under the *Mental Hospitals Act* shall designate one or more persons or categories of persons to perform the functions of a rights adviser under the act in the facility.
> (3) A psychiatric facility acting under subsection (2) may designate a person or persons or a category of persons designated by the Minister under subsection (1) but on doing so the facility shall inform the Minister of the designation.
> (4) A psychiatric facility may revoke a designation made under subsection (3).
> (5) A designation or revocation by a psychiatric facility shall be made on its behalf by the officer in charge.
>
> 14.1 The Minister shall designate one or more persons or categories of persons to perform the functions of a rights adviser under the act with respect to a person who is being considered for the issuance or renewal of a community treatment order where the person is not a patient in a psychiatric facility and may revoke such a designation.
>
> 14.2 Only persons who meet the following requirements may be designated to perform the functions of a rights adviser under the act whether in a psychiatric facility or with respect to a person who is being considered for the issuance or renewal of a community treatment order:
> 1. The person must be knowledgeable about the rights to apply to the board provided under the act, the Health Care Consent Act, 1996 and the Personal Health Information Protection Act, 2004.
> 2. The person must be knowledgeable about the workings of the board, how to contact the board and how to make applications to the board.
> 3. The person must be knowledgeable about how to obtain legal services.
> 4. The person must have the communications skills necessary to perform effectively the functions of a rights adviser under the act.

5. The person must have successfully completed a training course for rights advisers approved by the Minister and have been certified as having completed such a course.

14.3 (1) A physician who is considering issuing or renewing a community treatment order for a person under section 33.1 of the act shall give notice of his or her intention in the approved form to the person, the person's substitute decision-maker, if any, and to a rights adviser.

(2) A rights adviser who receives notice under subsection (1) shall promptly,

(a) provide rights advice to the person unless the person refuses the provision of rights advice;

(b) provide rights advice to the person's substitute decision-maker, if any.

(3) The rights adviser shall explain to the person and the substitute decision-maker, if any, the requirements for the issuance or renewal of a community treatment order, the significance of such an order, including any obligations that the person or the substitute decision-maker may be required to meet under the order.

(4) Where a rights adviser who receives notice under subsection (1) believes that it is in the best interest of the person to receive rights advice from another rights adviser, he or she shall ensure that a second rights adviser provides such advice.

(5) Where a rights adviser provides rights advice to the person and the substitute decision-maker, if any, the rights adviser shall promptly provide confirmation of that fact to the physician in the approved form.

(6) Where a person refuses the provision of rights advice, the rights adviser shall promptly provide confirmation of that fact to the physician in the approved form.

16. (1) A rights adviser fulfils his or her obligation under this regulation to explain a matter to a person if the rights adviser explains the matter to the best of his or her ability and in a manner that addresses the person's special needs, even if the person does not understand the explanation.

(2) In circumstances other than those described in subsections 14.3 (5) and (6), where a rights adviser is required to explain a matter to a person under the act, he or she shall provide confirmation that the explanation has been given to the attending physician or the officer in charge, as the case may be, in the approved form.

The rights advice mechanism appears to be working very well. Most patients, substitute decision-makers, and health professionals all told us that they are satisfied with the process. There appears to be widespread acceptance of the principle that rights advice is an essential part of the CTO process given the abrogation of personal rights inherent in the formulation of a community treatment order. Rights advisers are generally described as professional and knowledgeable.

Certain problems did, however, emerge in the course of our consultations. These issues are as follows:

- CTO coordinators told us that some substitute decision-makers did not appear to fully comprehend advice when provided by telephone.
- Some substitute decision-makers do not cooperate fully with the rights advice process. Some of them are hurried, others are obviously unhappy to receive rights advice, while others make difficult demands such as late-evening rights advice.
- Full rights advice is required for both the client and the substitute decision-maker (if any) each time a CTO is renewed. A number of substitute decision-makers expressed discomfort with the necessity of going through this process every six months.
- Officials of the office of the Treatment Decisions Unit of the Public Guardian and Trustee receive rights advice every time that they are the substitute decision-maker for a proposed community treatment plan.
- Rights advice is offered to patients at a time when they have no right of appeal to the Consent and Capacity Board, as that right only arises later in the process once the CTO has been issued. We are told, however, that rights advisers leave contact information with clients and are willing to re-attend.
- Some CTO coordinators report that the process is regularly delayed because of the need to wait inordinate periods of time for rights advice to be provided. It would appear, however, that the PPAO does its best within the resource base provided to provide rights advice as quickly as possible.
- PPAO policy prevents rights advisers from advising the physician when a patient applies to the Consent and Capacity Board. It is the position of the PPAO that the Consent and Capacity Board should advise the physician of the pending hearing. This practice, however, is at variance with accepted norms in the legal world. It causes administrative difficulties by preventing the physician and the hospital from finding out about pending hearings until close to the date when they will take place. It also causes a great deal of unneeded resentment on the part of health professionals.

• PPAO rights advice routinely goes beyond the straightforward information-giving process that is dictated by legislation and tradition. The PPAO head office demands a copy of the proposed treatment plan before rights advice is given. It is their position that this is done in order to allow them to prepare to provide rights advice. We heard, however, from health and helping professionals across the province that the PPAO is using the proposed treatment plans for far more than the preparation of rights advice. The PPAO routinely intercedes directly with hospitals when it feels that treatment plans are not in a form that they find acceptable. The PPAO told us that this is done simply as a courtesy and that no pressure is exerted. We have heard from the hospitals, however, that they are frequently given the impression that the PPAO has veto authority over treatment plans. While the problem appears to have abated somewhat over time, the practice still continues. According to our information, many CTO coordinators, relying on previous comments from the PPAO, refrain from including certain provisions in draft treatment plans in the belief that they are inappropriate or that they will not pass muster with the PPAO. We could find no statutory authority for this PPAO practice.

7.5 Prevalence and Effectiveness of the Use of Leaves of Absence (LOAs) as an Alternative to CTOs

Because the Ontario data on the use of leaves of absence is inconsistent and incomplete, we were not able to produce a picture of their utilization. Also, the literature does not fill this void in any significant way. Several jurisdictions use leaves of absence with or without conditions, but we are not aware of any studies that draw definitive conclusions after comparing the use of leaves of absence with the use of CTOs.

In Ontario, prior to the amendments of June 2000, section 27 of the *Mental Health Act* read as follows:

(1) The officer in charge may, upon the advice of the attending physician, place a patient on leave of absence from the psychiatric facility for a designated period of not more than three months, if the intention is that the patient shall return thereto.
(2) Leave of absence may be permitted upon such terms and conditions as the officer in charge may prescribe.
(3) Subsection (1) does not authorize the placing of a patient on a leave of absence where he or she is subject to detention otherwise than under this Act.

The amended section now reads as follows:

(1) The attending physician may, subject to subsection (3), place a patient on a leave of absence from the psychiatric facility for a designated period of not more than three months if the intention is that the patient shall return to the facility.
(2) The officer in charge may, upon the advice of the attending physician, place a patient on a leave of absence from the psychiatric facility for a designated period of not more than three months.
(3) The attending physician and the patient shall comply with such terms and conditions for the leave of absence as the officer in charge may prescribe.
(4) This section does not authorize the placing of a patient on a leave of absence where he or she is subject to detention otherwise than under this act.

The amendments significantly strengthened the leave of absence provisions in two important ways. Firstly and most significantly, the requirement that that there be an intention that, "the patient shall return to the facility" has been removed in the case of leaves of absence granted by the officer in charge of the facility. While the use of leaves of absence was previously limited to those patients who were expected to return to inpatient status at the conclusion of the leave, they are now available for use with patients who are not expected to be returning to the facility at the conclusion of the leave. Given this fact, nothing would appear to prevent the use of a leave of absence as a bridge to community reintegration or the use of successive leaves of absence as an alternative to a CTO.

The second important change is the fact that leaves of absence may now be granted by either the attending physician or the officer in charge. This change represents a substantial increase in the discretion that may be exercised by the attending physician without the need for intervention by the officer in charge. The attending physician, however, may only grant a leave if it is the intention that the patient shall return to the facility. It should also be noted that, whether the officer in charge or the attending physician grants the leave, only the officer in charge may impose terms and conditions on the leave.

While a leave of absence may be used with a voluntary, involuntary, or informal patient, they are only enforceable with regards to the involuntary or informal patient. A leave of absence with regards to a patient in either of these two categories could include a provision requiring the patient to return to the facility immediately should any of the terms and conditions be violated. It would appear that such a condition would allow the use of the police to return the patient in the same manner as any other patient who is unlawfully at large from the facility.

Placing a patient on a leave of absence does not give rise to a visit by the rights adviser or the right to apply to the Consent and Capacity Board for a review. Involuntary and informal patients are, however, entitled to rights advice and a board hearing by virtue of their status. Voluntary patients do not receive either rights advice or the right to a hearing.

Unlike CTOs, the use of a leaves of absence does not require a community treatment plan with defined roles for the various agencies and professionals or provide access to the CTO coordinator, a fast track to case management or enhanced access to other community services.

Historically, leaves of absence have not been widely used in Ontario. Generally they were used for weekend passes and the like although at some facilities, particularly provincial psychiatric hospitals, they were sometimes used for somewhat longer periods in order to prepare a patient for discharge into the community or as a means of gauging suitability for discharge. The requirement that the officer in charge issue the leave was widely ignored and leaves were generally granted by attending physicians.

It would appear that the amendments were designed to facilitate the much wider use of leaves of absence in the province. If this was the goal, it appears to have failed. With one notable exception, we found very little use of leaves of absence in the province other than for the traditional weekend or holiday passes. In fact, many practitioners told us that their use had atrophied over the years and that the amendments had done nothing to reverse this trend. With very few exceptions the psychiatrists, administrators and other professionals with whom we spoke were not aware of the amendments to the Leave of Absence provisions. In other words, there does not appear to have been a considered decision on the part of professionals not to use the amended provisions but, rather, a lack of awareness that they even exist.

There are three factors in addition to ignorance that severely impede the potential use of leaves of absence. The first of these is the perceived requirement that a bed be kept available for a patient who is out of the hospital on a Leave of Absence. While it is not at all clear that there is, in fact, such a requirement, the ubiquitous nature of this belief is quite remarkable. The second major factor is the widespread belief that individuals released on a Leave of Absence are not entitled to income support under the Ontario Disability Support Program (ODSP). This belief exists notwithstanding the fact that government policy clearly specifies that patients who are in the community on a Leave of Absence under the *Mental Health Act* are not to be denied ODSP for that reason. The third is the belief on the part of some practitioners that the use of leaves of absence could result in enhanced legal liability.

It should be noted that we were successful in identifying one psychiatric facility where leaves of absence are used for periods beyond holidays and weekends. Members of the psychiatry department at Mount Sinai Hospital in Toronto continue the occasional use of leaves and have found them to be very useful. They are, however, hesitant to use them routinely, given their view that leaves of absence have fewer rights protections than community treatment orders.

8.0 Conclusions and Recommendations

8.1 Conclusions about Best Practices

Based on all that we have heard and read, we are of the view that the CTO provisions in the legislation work best when:

- physicians and other professionals are willing to use CTOs, but only after first considering the other suitable alternatives
- clients and substitute decision-makers are consulted and involved in the formulation and execution of the community treatment plans and community treatment orders
- there is a coordinated continuum of care involving both hospital and community-based professionals and resources.

In light of the above, the project identified three locations that we believe should be recognized as best practice sites. These are Chatham, Sault Saint Marie, and the Niagara Peninsula. Our description of each program is based on the information provided by the professionals in that community.

Chatham

Chatham has been identified as a best practice site even though CTOs are not being utilized in the area. We were told that the various community mental health providers are in constant contact and work closely with the professionals at the local hospital. A mental health consumer in the community generally receives services from various professionals and agencies that work with each other as a team. If those professionals believe that hospital admission is advisable, they contact the hospital and admission is arranged directly to the unit.

Once the client is admitted to hospital, the discharge planning process begins. That process involves the community providers as well as hospital staff. Those professionals work together, along with the client, to plan a return to the community with all of the appropriate services in place. The senior members of the psychiatry service at the hospital and the leaders of the various agencies in the community meet regularly in order to ensure that services are delivered in an optimal fashion and to maintain their relationships.

The professionals from Chatham whom we met told us that they believe that the use of CTOs in their area would be redundant since the planning, accountability, and continuity of care that CTOs promote are achieved without the necessity for the formality or legal restrictions on the client that are inherent in community treatment orders.

Sault Ste. Marie and the Niagara Peninsula

Sault Ste. Marie has a long history of health partnerships drawing the hospital and numerous services in the community to the same table. This unique local culture has provided a foundation for the sorts of partnerships that have proven themselves to be crucial to a truly successful CTO program. The chief of psychiatry and his team have built on this history to forge close working relationships with various agencies in the community in order to create a network of services providing continuity of care extending from the hospital into the community and, when necessary, back to the hospital. Community partners are involved in the discharge planning process and the CTO coordinator and case manager work closely with community partners.

The Niagara Peninsula, like most other parts of the province, does not have such a history. In fact, the Niagara Health System itself, the local provider of hospital-based mental health services, is a recent amalgam of three hospitals with quite different histories and cultures. The relationship between these hospitals and agencies in the community has historically not been close. The manager of mental health services at the time they were introduced believed that CTOs had a crucial role to play and that that role could not be fulfilled unless close working relationships were forged with the community. She, therefore, sought out such partnerships and, together with like-minded individuals in both the hospital and the community, succeeded in overcoming resistance in order to forge an easy working relationship. Community agencies are now an integral part of the discharge planning process and have assumed a key role in supporting CTO clients in the community with housing and other necessary services.

In both Sault Ste. Marie and Niagara, the community and the hospital now work together to identify individuals who are well-suited for CTOs, carry them through the initial stages, and, thereafter, provide the level of support required in the community. In both communities, CTOs are only used after consideration of all appropriate options. Clients and families in both communities report a great deal of satisfaction with the program and we were told that readmission rates and hospitalization rates appear to have dropped significantly. And in both communities the relationship between hospital-based mental health professionals and those who support mental health clients in the community has significantly strengthened as the result of initiatives taken to support the CTO program.

8.2 The Challenge and the Dilemma

We have been asked to answer five questions and to make recommendations that are clearly linked to our key findings and to identify opportunities to improve both CTOs and the next legislated program review. Two of the questions relate to the reasons that CTOs were used or not used and the effectiveness of CTOs. The answers to those questions are key to formulating our recommendations with regards to improvements to both the next review and CTOs themselves.

As we travelled the province we heard repeatedly that community treatment orders have profoundly changed many lives and even saved lives. However, it is less than totally clear which factors, or combination of factors, have led to this apparent success. It is difficult to know whether the key is the order itself and the legal control over the patient that it conveys, the services and the treatment team that is frequently assembled to support the patient, or some combination of these factors.

We realized early on that many of the benefits of CTOs result from the way that they bring various professionals together, the professional accountability that they create, and the changes that they bring about in professional behaviour. Other critical factors are the presence of the coordinator, the creation of a framework that draws hospital and community providers together in a systematic fashion, and the availability of certain resources for the client that might otherwise not be available.

Notwithstanding the obvious success stories that we encountered, it became clear that CTOs are sometimes put in place and maintained in ways that appear to be calculated to circumvent the legal and procedural protections in the legislation. We note that while the protections appear to have been designed to ensure compliance with fundamental legal and Charter principles and internationally recognized standards to which Canada subscribes, the result is often different.

We met clients whose lives have emerged from darkness to light as the result of a CTO. But we met others who told us that they felt a tremendous sense of violation and lack of respect as the result of the way that they have been treated under their CTOs.

We talked to CTO clients, some of who had been found legally incapable of making decisions regarding their treatment, who felt themselves to be an integral part of the team that planned and formulated their community treatment plan. They felt invested in the plan and in control of their lives. But we met other CTO clients who told us that they were not consulted or involved in the formulation of their plan.

We heard of substitute decision-makers who felt that they had real choices and that their voices were heard during the formulation of the community treatment plan. We were told of other cases, however, where SDMs were presented with standard form agreements and had the impression that their only options were to sign or not sign.

We met physicians whose idealism and commitment to serving their patients was an inspiration. It became clear very quickly, however, that there exists a minority of psychiatrists for whom less-altruistic factors dictated, to a large extent, the treatment modalities that they chose for their patients.

Our challenge has been to make recommendations that will, if implemented:

- accentuate all that is good about CTOs
- address the obvious problems by suggesting checks and balances that will promote efficacious, measured and thoughtful use of CTOs in appropriate circumstances
- discourage their use when not appropriate.

Two of our objectives for this report are to recommend ways of better using CTOs in cases where they are indicated, and to encourage policies that are likely to reduce the need for CTOs in circumstances when their utility is questionable or other equally effective but less restrictive alternatives are available.

Given the experience gained in the course of this study and the paucity of definitive scientific data on the use and outcomes of CTOs in the province, we have also made recommendations relating to the structure of the next legislated review and the groundwork that must be prepared between now and then.

We believe that it is insufficient to address community treatment orders without commenting on the wider context in which those orders exist. CTOs are designed to facilitate the successful placement into the community of those suffering from serious and persistent mental illness. However, the best legislation in the world cannot achieve that task:

- unless these individuals are accepted as full, and productive citizens deserving of assistance and our respect
- unless these individuals are provided with the housing and other supports that they need to live in our society
- unless these individuals receive support in finding gainful employment and in finding ways for them to exercise a significant amount of autonomy and control over their own lives
- unless the stigma of mental illness becomes a thing of the past.

Given all of the above realities, we were faced with a dilemma. The legal control components of a CTO, by their very nature, impinge on elements of the client's autonomy that most members of society take for granted. It follows that the use of those components can only be justified if:

- they are a necessary element for the success of the CTO,
- the CTO is likely to be efficacious, and
- there is no reasonable alternative to the CTO other than hospitalization.

We have concluded that the appropriate path to follow is to make recommendations with regards to research that we believe should be commissioned at once so that the government can make decisions based on scientifically valid data.

Our recommendations are divided into five components as follows:

1. Administrative and regulatory changes to improve the functioning of CTOs that may be possible to implement in the short term pending the results of the research
2. Research into the necessity and efficacy of the legal component of CTOs
3. Legislative changes that could be enacted once that research has been received
4. Changes regarding rights advice and leaves of absence
5. Recommendations for the next statutory review and work that needs to be done in preparation for that review.

8.3 Recommendations

8.3.1 Proposed Administrative and Regulatory Changes to Improve CTOs

Our research established that numerous changes are indicated in order to bring substantial improvements to the CTO program and improve results. Some of these changes appear to require legislative amendments while others might be accomplished through administrative actions or changes to the regulations

We have included in this section only those changes that may be possible to implement through regulatory or administrative change. We have done this in light of the fact that changes to the legislation may well be indicated after the results of the research that we recommend below are known, and in recognition of the reality that there is little likelihood of two rounds of legislative amendment. Our recommendations regarding matters that require legislative change are set out in 8.3.3, below.

In formulating the above items we have attempted to restrict ourselves to recommendations that relate directly to CTOs. We are not so naive, however, as to believe that CTOs can succeed in promoting wellness and community reintegration unless the following needs are addressed:

- adequate levels of housing, employment, income support and other necessary services for those suffering from serious and persistent mental illness, appropriately distributed across the province
- multisectoral liaison and planning committees at the provincial, regional and local levels to focus the efforts of the justice, social services, education, housing and mental health sectors
- support for programs like consumer drop-in centres, consumer counsels, and consumer initiatives (such as consumer survivor managed businesses) across the province to encourage wellness, self-reliance, empowerment, autonomy and a sense of accomplishment and self-worth

- the planning, developing, overseeing and funding of a continuum of care for the seriously mentally ill, tying together inpatient and community services according to overall regional plans.

Our recommendations for administrative and regulatory changes follow.

It is stating the obvious to say that CTOs are appropriate for some clients and not for others, either because alternative, less intrusive services would be equally or more effective, or because a CTO cannot adequately address the needs of the client. Our review clearly identified some fundamental problems with the use of CTOs and the provision of resources that support community treatment plans under a CTO:

- In some parts of Ontario, because of a shortage of community mental health services, practitioners have resorted to placing individuals under a CTO in order that they may receive the community services that they need. These are individuals who would otherwise receive services in the community outside of a CTO if those services were available for them. As a result of this action, clients are compelled to forgo a portion of their personal autonomy. It also distorts the use of services that were put in place specifically to support clients who require the constraints of a CTO to be able to remain in the community.
- In some parts of Ontario, CTO clients are likely to see their supports terminated or radically altered at the termination of their CTO. This occurs, for example, because some agencies are funded only to support CTO clients, or the local ACT team or other community mental health programs may have waiting lists for new clients – which would include clients coming off a CTO. This results in the revolving door between the community and the hospital being delayed rather than being abolished.

Therefore, we recommend the following:

Recommendation 1:

The MOHLTC should review the process by which community mental health service resource allocation decisions are taken, with a view to making the changes necessary to ensure that these decisions do not affect the choice by psychiatrists and other health professionals as to which treatment modalities should be made available to a client requiring community mental health services.

Recommendation 2:

The MOHLTC should explore strategies to provide continuity of care for clients when their CTOs come to an end. Except in exceptional circumstances, the objectives should be to avoid transfer to different workers or different agencies, and especially to avoid a hiatus in service due to the presence of waiting lists.

We heard again and again in our travels that length of stay pressures are hampering the ability of hospital staff to bring patients to the state of health required as a necessary foundation for a successful CTO. We were told that a stay in excess of a minimal period would be actively discouraged while repeated short stays necessitated by the fact that the patient was sent home before he or she had reached a satisfactory state of wellness were encouraged by existing practices. Therefore, we recommend the following:

Recommendation 3:

The MOHLTC should explore the possibility of refining ministry policies and monitoring them, so that they do not inadvertently encourage discharge of CTO candidates from inpatient care before the groundwork for a successful CTO is in place. Consideration might be given, for example, to replacing length of stay measurements with total inpatient days over a one or two year period in the case of individuals suffering from serious mental illness.

The paperwork required to institute and maintain a CTO is unnecessarily complicated and is sometimes difficult to understand. The legislated forms do not support a straightforward approval process and a logical flow of information among the parties that have responsibilities under a CTO and its community treatment plan. Moreover, in addition to keeping their own records on CTO clients, physicians and other health service providers are required to file a variety of data reports with different parts of the ministry – data that appears not to have been used for any value-added purpose. As a result of the foregoing:

- valuable physician time has been unnecessarily diverted to form filling
- some physicians have been dissuaded from using CTOs when their use would be indicated
- some patient stays have been extended at significant expense and inconvenience.

We therefore recommend the following:

Recommendation 4:

MOHLTC experts in legal and mental health process design, as well as experts in forms design, should be assigned to re-engineer the form, data reporting and paper flow requirements for CTOs with the goal of simplifying the process and eliminating or combining forms. This process, however, should not attempt to eliminate the necessary steps of community treatment plan formulation, the provision of rights advice, consent to the plan, and issuance of the order.

The CTO coordinators across the province have proven themselves to be an indispensable resource at all stages of the CTO process. They educate, coordinate, and facilitate the process. They provide essential assistance to physicians and are a key link between clients, families, hospitals, and community agencies. Many of them have accumulated a great deal of clinical and legal expertise related to CTOs.

We believe, however, that changes are indicated so that coordinators call fulfill their potential as assurors of quality, consistency and compliance and so that best practices can be promoted across the province, and they can receive the support that they need to do their job.

We are of the view that CTO coordinators should be located in hospitals but should be employed by an appropriate community entity. This would allow them to fulfill an arm's-length quality assurance role, function as a community resource, and bring a wider community perspective to their work.

Coordinators should be required to fulfill the review function contemplated by subsection 81 (1) (g.2) of the *Mental Health Act* in order to bring necessary quality assurance. Therefore, we recommend the following:

Recommendation 5:

The MOHLTC should establish and fund an overall facilitating function for CTO coordinators that will:
- **provide continuing education for coordinators**
- **identify and promote best practices**
- **collect reliable CTO data with regards to CTO usage and efficacy**
- **arrange for summary legal advice and direction for coordinators**
- **define the role and qualifications for coordinators.**

Recommendation 6:

The MOHLTC should require that all CTO coordinators be located in a Schedule 1 facility, but be employed by and report to a non-hospital community entity.

Recommendation 7:

The MOHLTC should assign CTO coordinators an enhanced quality assurance role. Consideration should be given to designating them under the regulations as persons who may review community treatment order documents to ensure compliance with the act. They could be prescribed the additional duties of verifying and documenting on the face of the CTO whether or not:
- **consent was informed and voluntary**
- **a primary purpose of the CTO was to obtain services for the client**
- **less restrictive alternatives were considered for the client**
- **the client and the substitute decision-maker (if any) was involved in the development of the community treatment plan**
- **the community treatment plan includes initiatives to facilitate wellness such as employment, suitable housing, involvement in consumer initiatives, etc., and**
- **a plan is in place for continuity of services once that CTO comes to an end.**

Recommendation 8:

MOHLTC consideration should be given to the appointment of a small number of aboriginal CTO coordinators, with one in Northwestern Ontario and others in identified areas of the province. These coordinators should work in conjunction with the coordinators already in place.

With a few notable exceptions, CTOs have not been successful in rural Ontario. The successes are in areas where a concerted effort has been made by a major urban mental health service to support the rural service providers. Given the shortage of physicians in rural Ontario, it has also been suggested that nurse practitioners could play a key role in the successful introduction of CTOs to these areas. Therefore, we recommend the following:

Recommendation 9:

The MOHLTC should mandate, facilitate and encourage selected mental health service organizations to provide support to rural mental health services involved with CTO clients through the use of direct mentoring and technology.

Recommendation 10:

MOHLTC consideration should be given to funding positions for specialized mental health nurse practitioners to support CTO clients in rural and remote areas.

Employment or volunteer work is a crucial part of rehabilitation and wellness, and a key indicator of CTO success. Many positions require police confirmation that the person does not have a criminal record. In many parts of the province these reports routinely include information about non-criminal mental health-related contacts with the person that has not been requested. This practice creates unnecessary roadblocks to employment or volunteer placement for individuals who are already struggling to reintegrate into the community. Therefore, we recommend the following:

Recommendation 11:

The MOHLTC, in conjunction with the Ministry of Community Safety and Correctional Services, should consider taking the steps necessary to encourage police departments to end the practice of routinely disclosing interaction with individuals under the *Mental Health Act* when asked to confirm the lack of a criminal record.

Police forces, courts, jails, and parole offices across the province are inundated with individuals who suffer from serious and persistent mental illness. Experience in at least one part of the province has demonstrated the utility of using CTOs as part of a successful diversion strategy. Therefore, we recommend the following:

Recommendation 12:

The MOHLTC, in conjunction with the Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General, explore the possibility and advisability of using CTOs as part of the strategy for diverting those with serious and persistent mental illness from the justice system to the health system.

Many family members and other caregivers feel themselves to be disenfranchised and powerless in the system. Many find it difficult to advocate for their loved ones or access the services that they believe are needed. Currently, there is no province-wide facility offering this service. The creation of modest capacity to provide summary advice and basic advocacy would go a considerable distance towards levelling the playing field. Therefore, we recommend the following:

Recommendation 13:

MOHLTC consideration should be given to the establishment and funding of a family and caregiver advocacy service to provide advocacy and summary legal advice to family members, substitute decision-makers, and other informal caregivers of those suffering from serious and persistent mental illness.

The many concerns that we heard about the Consent and Capacity Board and the way it functions are having a major detrimental effect on physician conduct with regards to CTOs. While major progress is evident over the past year, a great deal of work remains. Steps should be taken to ensure that the legal review, at all of its stages, is more purposeful, focused, professional and respectful of all concerned. Therefore, we recommend the following:

Recommendation 14:

The Consent and Capacity Board should take steps to:

- **ensure that hearings are scheduled and parties notified within two business days of receipt of applications**
- **encourage compliance with common-law rules and existing direction from the courts with regard to matters such as the limits on rehearing decided issues and over-reliance on technical and procedural matters**
- **maintain a comprehensive initial and ongoing training program for board members, including but not limited to training in administrative law, control of proceedings and issues related to dealing with unrepresented parties.**

Recommendation 15:

The MOHLTC should:

- **ensure that the process of appointing and reappointing Consent and Capacity Board members results in consistent and high quality decision-making with regards to CTOs and related matters.**
- **explore the possibility of establishing a properly funded mechanism to provide physicians with the following:**
- **telephone summary legal advice on demand**
- **legal representation before the Consent and Capacity Board in appropriate cases**
- **guaranteed legal representation with regards to CTO appeals from the Consent and Capacity Board.**

Police play a significant role in CTO enforcement. Unfortunately, many police officers are reluctant to participate in the process because of their experience of waiting with patients for many hours in emergency rooms for the hospital to accept custody. Although attempts were made to address this issue in amendments to the act in 2000, the problem remains and the issue continues to hamper good relations between police and hospitals. Therefore, we recommend the following:

Recommendation 16:

The MOHLTC should consider an information program to ensure that police and hospital officials are aware of the provisions in the act and regulations that deal with hospitals accepting custody.

Recommendation 17:

Local MOHLTC officials should encourage hospitals to take steps designed to reduce police waiting time.

Recommendation 18:

MOHLTC consideration should be given to allowing police forces to charge hospitals at their private duty rates for all waits over a defined period of time.

Stakeholders across the province told us that a lack of reliable and ongoing legal and clinical information and education was severely hampering their ability to properly understand and apply the legislation, implement the program, and understanding their rights and their role. Therefore, we recommend the following:

Recommendation 19:

MOHLTC consideration should be given to the establishment or funding of:

- **a permanent program of ongoing information and legal education for providers, consumers, families and the public across the province regarding CTOs and related health law issues using on-site presentations, publications, and appropriate technologies**
- **a program utilizing psychiatrists with superior educational skills and expertise in CTOs and their alternatives to promote best practices and provide education to their peers across the province.**

8.3.2 Proposed Research into the Necessity and Efficacy of the Legal Component of CTOs

CTOs came into being in Ontario as a result of the 1995 killing of Brian Smith, an Ottawa television sports broadcaster, by a person who was subsequently found not criminally responsible in Smith's death due to his mental condition. While it was this act that led to the enactment of the legislative changes that implemented CTOs, a negligible number of CTO clients actually have any criminal involvement with the legal system (see Table 17: CTO client involvement with legal system in six months prior to current CTO). Thus, almost all CTO clients are placed under CTOs as a way of allowing them to live in the community rather than in a Schedule 1 psychiatric facility, and not as a way to control criminal behaviour.

It is clear that CTO clients have, overall, benefited greatly from the CTO program. What is not at all clear, however, is what portion of this success, if any, is attributable to the legal restrictions inherent in a CTO, as opposed to the programmatic, organizational and fiscal reasons.

We know from the experience in Chatham that satisfactory services can be provided to potential CTO clients outside of a CTO. Further study is required to determine whether this is due to the client mix, the way care is provided, or because of other factors. However, we do know from the experience in Chatham, the Niagara Peninsula and in Sault Ste. Marie that a willingness to collaborate between health professionals and other service providers, and between hospitals and community mental health and other local agencies, is a critical success factor in achieving their high level of satisfaction with CTOs and alternative treatment plans (see section 8.1 Conclusions about Best Practices). Given the provisions of the Canadian Charter of Rights and Freedoms and the internationally recognized standards to which Canada subscribes, it is difficult to justify the diminution of patient autonomy inherent in a CTO without a clear understanding of the role that legal restrictions play in the success of a CTO.

Our literature review failed to identify any compelling body of research in this regard (see section 3.3 Clinical Trial Evidence), and there appears to be a general consensus that more specific research needs to be undertaken.

Therefore, it is critical to know whether there is significant added value to justify the legally intrusive nature of CTOs, and also for which patients they are likely to be efficacious. In our view, there is no justification to continue the program in its current form in the long term without this information. Therefore, we recommend the following:

Recommendation 20:

The MOHLTC should monitor national and international research findings and commission scientifically rigorous Ontario-based research into:
- **the importance or lack thereof of the legal component of CTOs**
- **defining the profile of individuals likely to benefit or not benefit from the legal component of CTOs.**

8.3.3 Proposed Legislative Changes to be Considered Upon the Opening of the *Mental Health Act* to Amendments

Amendments consequential to the proposed research

When the research recommended in 8.2.2 is complete, it may be appropriate to consider amendments to the *Mental Health Act* in light of the conclusions. The research may indicate the desirability of widening or narrowing the CTO target group, preserving the status quo or removing the enforcement provisions from the legislation.

Other amendments

We are of the view that a number of amendments to the legislation may be advisable in order to improve the program. We recognize, however, that it is impractical to open the legislation more than once. Therefore, we recommend the following:

Recommendation 21:

The MOHLTC should delay the introduction of recommendations for legislative amendment until the conclusion of the research, so that they can be introduced at the same time as any amendments flowing from the research itself. If a decision is made not to proceed with the research, these amendments should be put before the legislature as soon as is practicable.

As with all highly invasive treatments, it is important that CTOs only be used when success is likely and other efficacious but less intrusive treatments have been considered and eliminated. It is the client who pays the price in terms of loss of autonomy and sometimes a feeling of a loss of dignity when placed on a CTO. Incorporation of this principle into the law will encourage a conscious weighing of the human cost versus the benefits and will help to bring the legislation better into line with good clinical practice as well as the *Canadian Charter of Rights and Freedoms* and international norms for legislation of this sort. Therefore, we recommend the following:

Recommendation 22:

The CTO criteria should be amended in order to require that less invasive treatment modalities be ruled out before a CTO is considered.

Because of the enhanced role and influence of the Substitute Decision-maker (SDM) in the case of CTOs, it is particularly important that the issue of unsuitable SDMs be dealt with. We, therefore, recommend the following:

Recommendation 23:

Consideration should be given to an amendment to the *Health Care Consent Act* allowing the client or the attending physician to apply to the CCB for a determination that the person who otherwise qualifies to act as SDM is to be struck from the list on the basis of unsuitability. Any amendment should provide that findings of unsuitability should clearly be restricted to cases where they are based on the prior history of the relationship between the client and the potential SDM and not, for example, the doctor's desire to find a more compliant SDM.

There is almost universal acceptance of the fact that apprehension under the enforcement provision of the legislation automatically cancels the CTO. This has created a great deal of cynicism, discouraged CTO use in situations where they might have been beneficial and created safety and treatment risks. Therefore, we recommend the following:

Recommendation 24:

The wording in the legislation should be clarified to ensure that use of a Form 47 does not nullify the CTO.

Police are unsure of the extent, if any, of their right of entry when executing an apprehension under a CTO. Police are finding it difficult to fulfill the requirement that an individual apprehended on the authority of a Form 47 must be brought to the signing physician or his or her designate. Therefore, we recommend the following:

Recommendation 25:

The act should be amended to clarify whether or not a police officer executing a Form 47 is entitled to forcibly enter a dwelling house in order to effect the apprehension.

Recommendation 26:

The act should be amended to provide that a CTO client apprehended on the authority of a Form 47 may be brought to either the responsible physician or designate or to the closest Schedule 1 facility that would then be required to liaise with the responsible physician or designate.

Under the current rules, periods of voluntary hospitalization are included in the qualifying period for a CTO. This creates a serious obstacle for consumers, some of whom are reluctant to seek out care out of fear that it will qualify them for a CTO. Therefore, we recommend the following:

Recommendation 27:

The act should be amended so that periods of voluntary hospitalization are not included in the qualifying period for a CTO.

The CCB is regularly required to adjourn hearings in order to order legal counsel for individuals who are or may be incapable. These adjournments are expensive to the system and a major contributor to dissatisfaction with the

board. A requirement that all patients have counsel would provide protection for clients and would resolve this issue. A similar rule existed for certain matters until years ago and functioned without difficulty. Therefore, we recommend the following:

Recommendation 28:

The act should be amended to require that all CTO clients appearing before the Consent and Capacity Board have legal representation.

We were told repeatedly during the consultations that the requirement that the patient meeting the Form 1 criteria unless currently hospitalized gives rise to anomalous results with regard to CTO renewals. We were told that many patients who have been successfully stabilized with the assistance of a CTO do not meet the Form 1 criteria because of the success of the program but would quickly deteriorate to the point of meeting those criteria if their CTO was allowed to lapse. Under the current wording, these patients are not technically candidates for renewal. In other words, it can be argued that CTOs can only legally be renewed for clients for whom the CTO has been a failure. Therefore, we recommend the following:

Recommendation 29:

The act should be amended to change the requirement that the CTO candidate must meet the Form 1 criteria, to a requirement that the practitioner is of the opinion that the client is likely to reach a state wherein he or she will meet the criteria within a defined period of time unless he or she is maintained on the CTO.

There is no provision in the legislation for amending the community treatment plan. This means that a plan cannot be amended to meet changing circumstances or be changed as the result of lessons learned. While changing the provisions of the plan has the potential for severe impact on the client, we believe that the lack of a mechanism for modest change imposes undesirable and unworkable rigidity and may lead to the inappropriate cessation of a CTO in circumstances where one is indicated. In our view, the introduction of a provision allowing for minor changes is desirable. Therefore, we recommend the following:

Recommendation 30:

The act should be amended to allow modest changes to the community treatment plan. Consent should not be required if the nature, expected benefits, material risks, and restrictions affecting the rights of the client are not significantly different from the nature, expected benefits, material risks, and restrictions affecting the rights of the client contained in the community treatment plan as originally worded.

The current system for issuing and renewing CTOs is problematic for both clients and their physicians. It is clear that the rules and principles for CTOs are often being circumvented and that individuals, sometimes of questionable capacity, are frequently being pressured into consenting to CTOs in a manner that may not constitute voluntary, informed consent. It appears that CTOs are sometimes utilized to secure community resources, or that they are being used without consideration of less restrictive alternatives. We heard again and again that six months is too short of a period for a CTO from a clinical point of view. We also heard complaints about the detrimental effect that frequent renewals with their complex and repetitive procedures and mandatory hearings have on the system. Therefore, we recommend the following:

Recommendation 31:

Serious consideration should be given to amending the act in a manner that enhances client protections while making the system more efficient, clinically appropriate, and less administratively burdensome for physicians.

While no solution is without problems of its own, one option would be to require an initial legal review to ensure compliance while reducing the long-term paper and administrative load in a manner that protects the patient's right to a hearing. Under this model, all CTOs would require a Consent and Capacity Board review within 14 days of implementation to confirm:

- the patient's capacity
- the bona fides of patient consent

- that the legally correct SDM has been sought out
- that the least restrictive alternative test has been met, and
- that the CTO prerequisites have otherwise been met.

The complex renewal process could then be replaced with a simple requirement that the responsible physician document the justification for the continuation or cessation of the CTO at set intervals in a manner similar to that used for renewing involuntary committal. Mandated periodic rights advice and the right to apply to the Consent and Capacity Board would still arise at specified times. Mandatory hearings could be abolished or made less frequent.

Other options that do not go as far in resolving the problems are:
- coupling the mandatory review at the outset of a CTO with longer terms, e.g., one year
- doing away with a legislated expiry date, i.e., make CTOs similar to the process used for financial incapacity, along with mandatory rights advice and Consent and Capacity Board hearings at specified periods.

No matter which route is chosen, the rights of CTO clients in the community would be better protected if they had access to independent advocacy services.

Too many individuals with serious and persistent mental illness find themselves repeatedly involved with the criminal justice system instead of the health system. Too many of these individuals are subjected to the indignities of criminal incarceration. The conditional release mechanisms of the criminal justice system are often ineffective with these individuals. Many of them have continual contact with the criminal justice system because their illness remains unaddressed and untreated by the health system. Indeed, it appears that many of these individuals do not have access to the health system. We are all familiar with the revolving door through the hospital yet, in a very real way, Ontario now has a second revolving door through which many mentally ill individuals constantly and repeatedly pass. Therefore, we recommend the following:

Recommendation 32:

If and only if the proposal for an initial mandatory hearing is adopted, consideration should be given to amending the requirement in the act for previous hospitalization so that the test may be met in any hospital, or in other custodial institutions where the person has been detained on the basis of a duly constituted legal authority and satisfactory evidence is available to indicate that the person would likely have met the hospitalization criteria of section 33.1 were he or she not to have been detained elsewhere.

Many mental health consumers and health professionals are offended by the term "Brian's Law." They believe that it criminalizes the client group and significantly adds to the already high degree of stigma. The term confuses many stakeholders who believe that CTOs are meant to be used only with those clients with a criminal background or likely to engage in criminal behaviour. Some clients who might otherwise be amenable to being placed on a CTO are reticent to do so because of the implications of the terminology and its implications. We recognize that the term was originally conceived as a mark of respect for Brian Smith. We are of the view, however, that the damage caused by use of the term is not justified. Other language in the CTO provisions of the act seems to be more suitable to the world of corrections than the realm of health care. Therefore, we recommend the following:

Recommendation 33:

The MOHLTC should remove all references to "Brian's Law" from their communications and publications. Consideration should also be given to amending the act to remove the term and make other changes in terminology to make the wording more respectful of consumers and more suitable for use in a health care milieu.

8.3.4 Changes Regarding Rights Advice and Leaves of Absence

Rights Advice

During our consultations we consistently received overall highly positive comments on the rights advice service provided by the PPAO. However, a number of important issues arose. We were told that telephone rights advice is problematic. We also heard that the PPAO, as a matter of policy, refuses to share applications with physicians or coordinators. Because of the legislative requirements, rights advice is delivered to officials of the substitute

decisions unit of the Office of the Public Guardian and Trustee every time they consent to a community treatment order. Because some of these individuals are involved in multiple CTO files, this may result in the same person unnecessarily receiving rights advice on numerous occasions every year.

We heard that a minority of substitute decision-makers do not willingly make themselves available to receive rights advice or are not as cooperative as might be expected with the process. Recipients of telephone rights advice appear to be less satisfied and less informed that those who receive rights advice in person. Therefore, we recommend the following:

Recommendation 34:

The MOHLTC should consider taking steps to further minimize telephone rights advice for clients and for substitute decision-makers who are located within the province.

Recommendation 35:

The MOHLTC should consider exempting officials of the Office of the Public Guardian and Trustee from the requirement to receive rights advice.

Recommendation 36:

The MOHLTC should instruct CTO Coordinators to inform SDMs that rights advice is a necessary and integral part of the process and that failure to cooperate fully with the rights advice process will be seen as failure to make oneself available as an SDM.

The PPAO rights advice program has taken upon itself the non-statutorily sanctioned task of review and commenting on treatment plans. As a result, many rights advisers and physicians have erroneously assumed that the PPAO has the authority to withhold its approval of treatment plans. This creates needless animosity, is unfair to physicians, may delay hearings, and violates widely accepted legal norms.

The PPAO policy that prevents rights advisers from providing physicians and hospitals with copies of pending applications to the Consent and Capacity Board also violates accepted legal norms, slows down the system, raises costs, and causes needless animosity.

Therefore, we recommend the following:

Recommendation 37:

The PPAO should stop its practice of commenting to physicians and coordinators on the legality or propriety of treatment plans.

Recommendation 38:

Consideration should be given by the MOHLTC to changing the regulations to require that a copy of applications to the Consent and Capacity Board be provided to the CTO coordinator and/or the physicians within one hour of signature.

Leaves of Absence

With minor exceptions, the amendments to section 27 of the act that were passed in the year 2000 have not had the apparently intended effect of encouraging the use of leaves of absence as an alternative to extended inpatient stays, release without supervision and community treatment orders. We believe, however, that they clearly have the potential of accomplishing these goals if appropriate changes are made.

Necessary changes include the implementation of an education and information strategy and amendments to the act to deal with physicians' concerns regarding legal liability. Therefore, we recommend the following:

Recommendation 39:
The MOHLTC should consider amending the act in order to provide physicians with the same protection from liability that they enjoy with regards to CTOs.

Shorter LOA should remain a flexible and easy-to-use instrument to allow for weekend and holidays passes and

the like. However, we are of the view that successful, long-term LOAs clearly require the same level of service, planning, and communication as CTOs. Therefore, we recommend the following:

Recommendation 40:

The MOHLTC should consider amending the act to require a community treatment plan for all LOAs over 30 days.

Recommendation 41:

The MOHLTC should consider expanding the role of CTO coordinators and/or hospital staff with similar functions to include the development and management of community treatment plans for LOAs over 30 days.

Health professionals share a nearly universal ignorance of the LOA provisions. Much of the little information that they do have is incorrect. Vigorous action to address the information gap is required if LOA utilization in the province is to increase. Therefore, we recommend the following:

Recommendation 42:

The MOHLTC should ensure that:
- **education about the clinical and legal aspects of LOAs is included in the educational efforts recommended herein**
- **every Schedule 1 facility receives an information package regarding leaves of absence in order to dispel erroneous beliefs such as the false belief that LOA clients do not qualify for ODSP**
- **related MOHLTC procedures and communications are reviewed in order to ensure that they do not:**
  - **convey the impression that a bed must be kept open for each LOA client**
  - **inadvertently have the effect of discouraging LOA use.**

Leaves of absence are potentially at least as powerful as community treatment orders. If their use becomes widespread many of the same issues are likely to arise. Therefore, we recommend the following:

Recommendation 43:

The MOHLTC should ensure that leaves of absence remain a part of future CTO legislated reviews in order to monitor their effectiveness, and in the possibility that a higher degree of rights protection is required. In order to have the necessary leave of absence data available, the hospital daily census reports to the MOHLTC will have to identify leaves of absence for a hospital's major programs.

8.3.5 Recommendations for the Next Statutory Review and Work that Needs to be Done in Preparation for that Review

As we discussed CTOs with stakeholders, as we reviewed Canadian and international literature on CTOs, and as we attempted to put together quantitative data that would provide a picture of the functioning of the CTO program, obvious gaps and other problems arose. In this section we have summarized these. Dealing with them is fundamental to the ability of the next reviewers to meet the legislated mandate five years hence.

8.3.5.1 Scope of the next review

It is clear that CTOs are simply one treatment approach among many. They are not a cure all or a magic bullet. By establishing an ongoing structure that only reviews CTOs, undue emphasis is being placed on this treatment approach to the exclusion of all others and on the general issues related to the pursuit of wellness.

The underlying purpose of CTOs is to provide a program by which psychiatric inpatient care can be avoided when appropriate. However, this also applies to other community mental health programs that are designed to allow an individual to live in the community either permanently or with intermittent hospitalizations to deal with periodic problems.

The Government of Ontario regularly undertakes program reviews, whether for efficacy, financial, accountability or other reasons. The MOHLTC added two additional areas for review and several sub-questions to the three

legislated matters that were required to be the subject of this review. This willingness to go beyond the legislated boundaries is to be commended and should be continued for the review five years hence.

Therefore, we recommend the following:

Recommendation 44:

The MOHLTC should expand the scope of the next review to deal with the related aspects of community mental health care and wellness.

While much thought and deliberation should go into determining the full scope of the terms of reference for the next review, the following list might provide a useful starting point for discussion:

- The terms of reference for this review, i.e.:
  - the three legislated matters and the MOHLTC additional questions
  - the use of leaves of absence
  - the provision of rights advice
- What are the hospitalization rates for persons with similar mental health problems who are on a CTO, or who are receiving care through community mental health and/or other programs without a CTO?
- What is the (subjective) comparison between how well persons with similar mental health problems are able to function in the community under a CTO, or through care provided by community mental health and/or other programs without a CTO?
- What is the elapsed time that clients are under a CTO, or its renewal or reissue, and what happens to them after the CTO lapses?
- What portion, if any, of the success of CTOs is attributable to factors such as resource allocation and the organization of service delivery rather than the legal ramifications for the client?
- What is the opportunity cost of CTOs in terms of other priorities not serviced?
- Should CTOs be continued, or are there better alternatives?
- Look at rights issues – Are legal principles being complied with?
- To what extent are alternatives to CTOs being used and what can and should be done to promote their use?
- Why are various community programs being used?
- How do you evaluate and what is the cost of loss of rights?
- Do CTOs serve the purpose that they were established to serve?
- Who is, and who is not, a suitable candidate for CTOs?
- Do CTOs provide value for money, or would it be better to direct the resources elsewhere in support of keeping potential CTO clients in the community?
- Why are CTOs being used or not being used for adolescents and the elderly?

Establishing the scope of the next review sooner rather than later will allow MOHLTC staff to better define the data that will be needed to support the review, to allow sufficient time for systems (both manual and electronic) to be changed, and for the data to be collected. Much of this data will inevitably be required for the proposed research.

8.3.5.2 Data

There are obvious problems related to the MOHLTC's efforts to obtain quality data. These problems exist everywhere in both the public and private sectors. They include:

- fragmentation of data sources (both location and technology)
- minimal or no use of data leading to sub-optimal data quality
- lack of incentives/disincentives for timeliness, completeness and accuracy
- privacy concerns.

More specifically, as explained in section 4.0 Data, the MOHLTC's supplementary OHIP physician reporting form for CTOs, the *Community Treatment Order (CTO) Report Log*, and the *Community Treatment Order (CTO) Information Record* forms Access database are incomplete and contain inaccuracies.

Moreover, the MOHLTC's Ontario Mental Health Reporting System (OMHRS), Mental Health and Addictions Branch MIS Compliant Reporting, OHIP, Hospital Daily Census, etc. systems are not currently able to accept detailed CTO-related data, and hospital, agency and health professional systems are not currently set up to collect consistent CTO-related data and transmit it to the MOHLTC. Probably the most significant reason for this is that

CTOs are a very small part of the community mental health care system and are an even smaller part of the overall health care system.

A related issue is that the OHIP *Community Treatment Order (CTO) Report Log* and the *Community Treatment Order (CTO) Information Record* forms were designed in anticipation of this review. This was done before it was possible to know the full terms of reference for the review and before there was any experience with CTOs and how they would work. However, even if the MOHLTC can now identify with reasonable accuracy the data required for the next review, the challenge is to ensure that it receives timely, comprehensive and accurate data during the next five years.

Only with better information than now exists can two of the three statutory matters be adequately reviewed, i.e., the effectiveness of community treatment orders during the review period, and the methods used to evaluate the outcome of any treatment used under community treatment orders.

We believe that the types of data collected about CTO clients should be broadened and based on the need to support the recommended research, as well as the wider scope recommended for the next review. While these requirements should drive the definition of the data to be collected, useful reference points for discussion are provided by the data collected in the Community Mental Health Evaluation Initiative (*Making a Difference, Ontario's Community Mental Health Evaluation Initiative*, October 2004 – www.ontario.cmha.ca/cmhei) and through the Ontario Federation of Community Mental Health and Addiction Programs PSR Toolkit, the Canadian toolkit for measuring psychosocial rehabilitation outcomes (www.psr.ofcmhap.on.ca). They cover basic information on gender, age, education, marital status, employment/volunteering and finances, health/illness and utilization of health services/medications, living arrangements, legal issues, etc. Information is also collected about community integration, participation in community services and support programs, social supports, quality of life, feelings about empowerment, coping, and so on. If the data is collected over an extended period of time, it becomes a valuable tool for tracking changes that occur with respect to participating individuals and, ultimately, in the evaluation of program outcomes.

In our recommendations we suggest a stronger role for CTO coordinators. If this approach is implemented, CTO coordinators could also become the custodians/coordinators of CTO data. Therefore, we recommend the following:

Recommendation 45:

The MOHLTC should enhance the role of CTO coordinators by giving them the responsibility and authority to act as CTO data coordinators, and the MOHLTC should provide CTO coordinators with local hardware, if necessary, and appropriate software that would allow them to:

- **maintain their CTO-related records**
- **edit and abstract required data and transmit it electronically to the MOHLTC**
- **to produce reports that would be both useful and of interest to those physicians and others involved in initiating or providing care through CTOs, as well as for overall planning and monitoring the CTO program.**

9.0 Appendices

9.1 Selected Bibliography

Ajzenstadt, M., Aviram, U., Kalian, M. and Kanter, A. (2001). Involuntary outpatient commitment in Israel: Treatment or control? *International Journal of Law and Psychiatry*, 24(6), 637-657.

Allen, M., and Smith, V. F. (2001). Opening Pandora's box: The practical and legal dangers of involuntary outpatient commitment. *Psychiatric Services* (Washington, D.C.), 52(3), 342-346.

American Psychiatric Association. Task Force on Involuntary Outpatient Commitment, and American Psychiatric Association. (1987). *Involuntary commitment to outpatient treatment: Report of the task force on involuntary outpatient commitment*. Washington, D.C.: American Psychiatric Association.

Appelbaum, P. S. (2003). Ambivalence codified: California's new outpatient commitment statute. *Psychiatric Services* (Washington, D.C.), 54(1), 26-28.

Appelbaum, P. S. (2001). Thinking carefully about outpatient commitment. *Psychiatric Services* (Washington, D.C.), 52(3), 347-350.

Appelbaum, P. S. (1986). Outpatient commitment: The problems and the promise. *The American Journal of Psychiatry*, 143(10), 1270-1272.

Bloom, H. and Bay, M. (1996). *A practical guide to mental health, capacity and consent law of Ontario*. Scarborough, Ont.: Carswell.

Borum, R., Swartz, M., Riley, S., Swanson, J., Hiday, V. A. and Wagner, R. (1999). Consumer perceptions of involuntary outpatient commitment. *Psychiatric Services* (Washington, D.C.), 50(11), 1489-1491.

Boudreau, F. and Lambert, P. (1993). Compulsory community treatment? I. Ontario stakeholders' responses to helping those who won't help themselves. *Canadian Journal of Community Mental Health = Revue Canadienne De Sante Mentale Communautaire*, 12(1), 57-78.

Boudreau, F. and Lambert, P. (1993). Compulsory community treatment? II. the collision of views and complexities involved: Is it the best possible alternative? *Canadian Journal of Community Mental Health = Revue Canadienne De Sante Mentale Communautaire*, 12(1), 79-96.

Brahams, D. (1986). Treatment of uncooperative psychiatric patients in the community: Mental health act in need of reform. *Lancet*, 1(8485), 863-864.

Brown, J. D. (2003). Is involuntary outpatient commitment a remedy for community mental health service failure? *Ethical Hum.Sci.Serv.*, 5(1), 7-20.

Bursten, B. (1987). Mandatory outpatient treatment. *The American Journal of Psychiatry*, 144(3), 389-390.

Bursten, B. (1986). Posthospital mandatory outpatient treatment. *The American Journal of Psychiatry*, 143(10), 1255-1258.

Canadian Psychiatric Association. (2003). *CPA position paper: Mandatory outpatient treatment*. Retrieved from (http://www.psychdirect.com/forensic/PsychLaw/cto/pos_paper_mandatory_treat.htm).

Cantor, C. and Jones, D. (1998). Intravenous sedation of involuntary psychiatric patients in New South Wales. *The Australian and New Zealand Journal of Psychiatry*, 32(1), 141-143.

Canvin, K., Bartlett, A. and Pinfold, V. (2005). Acceptability of compulsory powers in the community: The ethical considerations of mental health service users on supervised discharge and guardianship. *Journal of Medical Ethics*, 31(8), 457-462.

Canvin, K., Bartlett, A. and Pinfold, V. (2002). A 'bittersweet pill to swallow': Learning from mental health service users' responses to compulsory community care in England. *Health.Soc.Care.Community*, 10(5), 361-369.

Cashman, F. (1997). Outpatient involuntary commitment. *Health Law in Canada*, 17(4), 127-131.

Caulfield, T. A. and Von Tigerstrom, B. (2002). *Health care reform and the law in Canada: Meeting the challenge*. Edmonton: University of Alberta Press.

Chaimowitz, G. A. (2004). Community treatment orders: An uncertain step. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 49(9), 577-578.

Chandrasena, R. (1991). The Ontario mental health act: A review of court decisions on involuntary committal. *Health Law in Canada*, 11(4), 97-101.

Chodoff, P. (1984). Involuntary hospitalization of the mentally ill as a moral issue. *The American Journal of Psychiatry*, 141(3), 384-389.

Compton, S. N., Swanson, J. W., Wagner, H. R., Swartz, M. S., Burns, B. J. and Elbogen, E. B. (2003). Involuntary outpatient commitment and homelessness in persons with severe mental illness. *Mental Health Services Research*, 5(1), 27-38.

Currier, G. W. (1997). A survey of New Zealand psychiatrists' clinical experience with the mental health (compulsory assessment and treatment) act of 1992. *The New Zealand Medical Journal*, 110(1036), 6-9.

Davies, S. (2000). Involuntary outpatient commitment and supervised discharge. *The British Journal of Psychiatry; the Journal of Mental Science*, 177, 183.

Dawson, J. (2005). *Community Treatment Orders: International Comparisons*. New Zealand: Otago University Print. Retrieved 2005, from http://www.otago.ac.nz/law/otagoCTO/publications/pdfs/CTO_Report_Summary.pdf

Dawson, J. Romans, S., Gibbs, A., Mullen, R., Ratter, N. and Ansley, C. et al. (2002). The proper uses of community treatment orders. [1]. *Legal research foundation conference: "critical topics in mental health law, policy and procedure"*, Auckland, New Zealand, retrieved from *http://legalresearch.auckland.ac.nz/docs/ProperUsesOfCommTOs.pdf*

Dawson, J. (2002). Randomised controlled trials of mental health legislation. *Med.Law.Rev.*, 10(3), 308-321.

Dawson, J. and Romans, S. (2001). Uses of community treatment orders in New Zealand: Early findings. *The Australian and New Zealand Journal of Psychiatry*, 35(2), 190-195.

Dawson, J., Romans, S., Gibbs, A. and Ratter, N. (2003). Ambivalence about community treatment orders. *International Journal of Law and Psychiatry*, 26(3), 243-255.

Delaney, T. (1999). Behavioral health issue brief: Outpatient civil commitment. *Issue Brief (Health Policy Tracking Service)*, 1-19.

Diamond, R. J. (1995). Coercion in the community: Issues for mature treatment systems. *New Directions for Mental Health Services*, 66 (Summer), 3-18.

Draine, J. (1997). Conceptualizing services research on outpatient commitment. *Journal of Mental Health Administration*, 24(3), 306-315.

Drake, R. E. and Burns, B. J. (1995). Special section on assertive community treatment: An introduction. *Psychiatric Services* (Washington, D.C.), 46(7), 667-668.

Dunn, J. (1989). Compulsory treatment in the community. *BMJ (Clinical Research Ed.)*, 298(6688), 1647.

Durst, R., Teitelbaum, A., Bar-El, Y., Shlafman, M. and Ginath, Y. (1999). Evaluation of compulsory ambulatory treatment in Israel. *Psychiatric Services* (Washington, D.C.), 50(5), 698-700.

Durst, R., Teitelbaum, A., Bar-el, Y., Shlafman, M. and Ginath, Y. (1997). [Compulsory, ambulatory psychiatric treatment]. *Harefuah*, 133(12), 597-602, 664.

Dyer, C. (1987). Compulsory treatment in the community for the mentally ill? *British Medical Journal (Clinical Research Ed.)*, 295(6604), 991-992.

El, Y. C., Durst, R., Rabinowitz, J., Kalian, M., Teitelbaum, A. and Shlafman, M. (1998). Implementation of order of compulsory ambulatory treatment in Jerusalem. *International Journal of Law and Psychiatry*, 21(1), 65-71.

Elbogen, E. B., Swanson, J. W. and Swartz, M. S. (2003). Effects of legal mechanisms on perceived coercion and treatment adherence among persons with severe mental illness. *The Journal of Nervous and Mental Disease*, 191(10), 629-637.

Everett, B. (2001). Community treatment orders: Ethical practice in an era of magical thinking. *Canadian Journal of Community Mental Health = Revue Canadienne De Sante Mentale Communautaire*, 20(1), 5-20.

Fahndrich, E. and Eichler, G. (1995). [Commitment of mentally ill and community psychiatry]. *Psychiatrische Praxis*, 22(4), 150-153.

Fennell, P. (1992). Balancing care and control: Guardianship, community treatment orders and patient safeguards. *International Journal of Law and Psychiatry*, 15(2), 205-235.

Fernandez, G. A. and Nygard, S. (1990). Impact of involuntary outpatient commitment on the revolving-door syndrome in North Carolina. *Hospital and Community Psychiatry*, 41(9), 1001-1004.

Fernandez, G. A. and North Carolina. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Evaluation Unit. (1992). *Evaluation of involuntary outpatient commitment in North Carolina*. Raleigh, N.C.: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Administrative Services Section, Evaluation Unit.

Fulop, N. J. (1995). Involuntary outpatient civil commitment: What can Britain learn from the U.S. experience? A civil liberties perspective. *International Journal of Law and Psychiatry*, 18(3), 291-303.

Garfinkel, P. E. and Goldbloom, D. S. (2000). Significant developments in psychiatry: Implications for community mental health. *Canadian Journal of Community Mental Health = Revue Canadienne De Sante Mentale Communautaire*, 19(2), 161-165.

Geller, J., Grudzinskas, A. J., Jr., McDermeit, M., Fisher, W. H. and Lawlor, T. (1998). The efficacy of involuntary outpatient treatment in Massachusetts. *Administration and Policy in Mental Health*, 25(3), 271-285.

Geller, J. L. (2000). At the margins of human rights and psychiatric care in North America. *Acta Psychiatrica Scandinavica. Supplementum*, 399, 87-92.

Geller, J. L. (1996). Making 'em do it. *Psychiatric Services* (Washington, D.C.), 47(11), 1157.

Geller, J. L. (1995). A biopsychosocial rationale for coerced community treatment in the management of schizophrenia. *The Psychiatric Quarterly*, 66(3), 219-235.

Geller, J. L. (1990). Clinical guidelines for the use of involuntary outpatient treatment. *Hospital and Community Psychiatry*, 41(7), 749-755.

Geller, J. L. (1986). The quandaries of enforced community treatment and unenforceable outpatient commitment statutes. *J.Psychiatry.Law.*, 14(1-2), 149-158.

Geller, J. L. (1986). Rights, wrongs, and the dilemma of coerced community treatment. *The American Journal of Psychiatry*, 143(10), 1259-1264.

Geller, J. L., McDermeit, M., Grudzinskas, A. J., Jr., Lawlor, T. and Fisher, W. H. (1997). A competency-based approach to court-ordered outpatient treatment. *New Directions for Mental Health Services*, (75), 81-95.

Gerbasi, J. B., Bonnie, R. J. and Binder, R. L. (2000). Resource document on mandatory outpatient treatment. *The Journal of the American Academy of Psychiatry and the Law*, 28(2), 127-144.

Gibbs, A., Dawson, J., Forsyth, H., Mullen, R. and Te Oranga Tonu Tanga (Maori Mental Health Team). (2004). Maori experience of community treatment orders in Otago, New Zealand. *The Australian and New Zealand Journal of Psychiatry*, 38(10), 830-835.

Gray, J. E. and O'Reilly, R. L. (2005). Canadian compulsory community treatment laws: Recent reforms. *International Journal of Law and Psychiatry*, 28(1), 13-22.

Gray, J. E. and O'Reilly, R. L. (2001). Clinically significant differences among Canadian mental health acts. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 46(4), 315-321.

Gray, J. E., Shone, M. A. and Liddle, P. F. (2000). *Canadian mental health law and policy*. Toronto, Ont.: Butterworths.

Greenberg, D., Mazar, J., Brom, D. and Barer, Y. C. (2005). Involuntary outpatient commitment: A naturalistic study of its use and a consumer survey at one community mental health center in Israel. *Medicine and Law*, 24(1), 95-110.

Groff, A., Burns, B., Swanson, J., Swartz, M., Wagner, H. R. and Tompson, M. (2004). Caregiving for persons with mental illness: The impact of outpatient commitment on caregiving strain. *The Journal of Nervous and Mental Disease*, 192(8), 554-562.

Hannigan, B. and Cutcliffe, J. (2002). Challenging contemporary mental health policy: Time to assuage the coercion? *Journal of Advanced Nursing*, 37(5), 477-484.

Heffern, W. A. and Austin, W. (1999). Compulsory community treatment: Ethical considerations. *Journal of Psychiatric and Mental Health Nursing*, 6(1), 37-42.

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K. and Szmukler, G. (2004). Effect of joint crisis plans on use of compulsory treatment in psychiatry: Single blind randomised controlled trial. *BMJ (Clinical Research Ed.)*, 329(7458), 136.

Hiday, V. A. and Goodman, R. R. (1982). The least restrictive alternative to involuntary hospitalization, outpatient commitment: Its use and effectiveness. *J.Psychiatry.Law.*, 10(1), 81-96.

Hiday, V. A. and Scheid-Cook, T. L. (1991). Outpatient commitment for revolving door patients: Compliance and treatment. *The Journal of Nervous and Mental Disease*, 179(2), 83-88.

Hiday, V. A. and Scheid-Cook, T. L. (1989). A follow-up of chronic patients committed to outpatient treatment. *Hospital and Community Psychiatry*, 40(1), 52-59.

Hiday, V. A. and Scheid-Cook, T. L. (1987). The North Carolina experience with outpatient commitment: A critical appraisal. *International Journal of Law and Psychiatry*, 10(3), 215-232.

Hiday, V. A., Swartz, M. S., Swanson, J. W., Borum, R. and Wagner, H. R. (2002). Impact of outpatient commitment on victimization of people with severe mental illness. *The American Journal of Psychiatry*, 159(8), 1403-1411.

Hiltz, D. and Szigeti, A. (2005). *A guide to consent and capacity law in Ontario* (2006th ed.). Markham, Ont.: LexisNexis Butterworths.

Hinds, J. T. (1990). Involuntary outpatient commitment for the chronically mentally ill. *Neb.Law.Rev.*, 69(2), 346-412.

Hoge, M. A. and Grottole, E. (2000). The case against outpatient commitment. *The Journal of the American Academy of Psychiatry and the Law*, 28(2), 165-170.

Holloway, F. (1996). Community psychiatric care: From libertarianism to coercion, moral panic and mental health policy in Britain. *Health Care Analysis: HCA: Journal of Health Philosophy and Policy*, 4(3), 235-243.

Keilitz, I. (1988). NCSC guidelines for involuntary civil commitment: A workable framework for justice in practice. *Hospital and Community Psychiatry*, 39(4), 398-402.

Keilitz, I. and Hall, T. (1985). State statutes governing involuntary outpatient civil commitment. *Mental and Physical Disability Law Reporter*, 9(5), 378-397.

Kisely, S., Campbell, L. A. and Preston, N. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *The Cochrane Database of Systematic Reviews*, 2005 Issue 3.

Kisely, S. R., Xiao, J. and Preston, N. J. (2004). Impact of compulsory community treatment on admission rates: Survival analysis using linked mental health and offender databases. *The British Journal of Psychiatry; the Journal of Mental Science*, 184, 432-438.

Knecht, G., Schanda, H., Berner, W., Morawitz, I. and Haubenstock, E. (1996). Outpatient treatment of mentally disordered offenders in Austria. *International Journal of Law and Psychiatry*, 19(1), 87-91.

Lamb, H. R. (1994). Reform of mental health laws: Not repeating the mistakes made in the United States. *The Japanese Journal of Psychiatry and Neurology*, Suppl. 48, 105-110.

Lamb, H. R. and Weinberger, L. E. (2000). Commentary: A major advance in the laws pertaining to community treatment for persons with severe mental illness. *The Journal of the American Academy of Psychiatry and the Law*, 28(2), 149-153.

Lefkovitch, Y., Weiser, M. and Levy, A. (1993). Involuntary outpatient commitment: Ethics and problems. *Medicine and Law*, 12(3-5), 213-220.

Levenson, J. L. (1986). Psychiatric commitment and involuntary hospitalization: An ethical perspective. *The Psychiatric Quarterly*, 58(2), 106-112.

Levkowitch, Y., Weiser, M., Levy, A. and Neumann, M. (1993). [Involuntary outpatient commitment: Ethical and legal aspects]. *Harefuah*, 124(11), 669-72, 740.

Loue, S. (2003). The involuntary civil commitment of mentally ill persons in the United States and Romania: A comparative analysis. *Rev.Rom.Bioet*, 1(1), 55-88.

McIvor, R. (1998). The community treatment order: Clinical and ethical issues. *The Australian and New Zealand Journal of Psychiatry*, 32(2), 223-228.

McLaren, S. and Cookson, J. (1989). Community treatment orders for mental illness. *Lancet*, 2(8677), 1457.

Mellor, P. (1987). Compulsory treatment in the community. *Nursing Standard (Royal College of Nursing (Great Britain): 1987)*, (495), 5.

Meloy, J. R., Haroun, A. and Schiller, E. F. (1990). *Clinical guidelines for involuntary outpatient treatment*. Sarasota, Fla.: Professional Resource Exchange.

Miller, R. D. (1992). An update on involuntary civil commitment to outpatient treatment. *Hospital and Community Psychiatry*, 43(1), 79-81.

Miller, R. D. (1982). The least restrictive alternative: Hidden meanings and agendas. *Community Mental Health Journal*, 18(1), 46-55.

Miller, R. D. and Fiddleman, P. B. (1984). Outpatient commitment: Treatment in the least restrictive environment? *Hospital and Community Psychiatry*, 35(2), 147-151.

Ministry of Health and Long-Term Care. (2001). *Rights and responsibilities: Mental health and the law*. Toronto: Ministry of Health and Long-Term Care.

Monahan, J., Bonnie, R. J., Appelbaum, P. S., Hyde, P. S., Steadman, H. J. and Swartz, M. S. (2001). Mandated community treatment: Beyond outpatient commitment. *Psychiatric Services* (Washington, D.C.), 52(9), 1198-1205.

Monahan, J., Swartz, M. and Bonnie, R. J. (2003). Mandated treatment in the community for people with mental disorders. *Health Affairs (Project Hope)*, 22(5), 28-38.

Moncrieff, J. (2003). The politics of a new mental health act. *The British Journal of Psychiatry; the Journal of Mental Science*, 183, 8-9.

Mulvey, E. P., Geller, J. L. and Roth, L. H. (1987). The promise and peril of involuntary outpatient commitment. *The American Psychologist*, 42(6), 571-584.

Munetz, M. R., Galon, P. A. and Frese, F. J., III (2003). The ethics of mandatory community treatment. *The Journal of the American Academy of Psychiatry and the Law*, 31(2), 173-183.

Munetz, M. R. and Geller, J. L. (1993). The least restrictive alternative in the postinstitutional era. *Hospital and Community Psychiatry*, 44(10), 967-973.

Munetz, M. R., Geller, J. L. and Frese, F. J., III (2000). Commentary: Capacity-based involuntary outpatient treatment. *The Journal of the American Academy of Psychiatry and the Law*, 28(2), 145-148.

Nordentoft, M., Knudsen, H. C., Jessen-Petersen, B., Krasnik, A., Saelan, H. and Brodersen, A. M. et al. (1997). Copenhagen community psychiatric project (CCPP): Characteristics and treatment of homeless patients in the psychiatric services after introduction of community mental health centres. *Social Psychiatry and Psychiatric Epidemiology*, 32(7), 369-378.

O'Brien, A. M. and Farrell, S. J. (2005). Community treatment orders: Profile of a Canadian experience. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 50(1), 27-30.

O'Reilly, R. (2004). Why are community treatment orders controversial? *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 49(9), 579-584.

O'Reilly, R. and Bishop, J. (2001). Assessing the New York City involuntary outpatient treatment program. *Psychiatric Services* (Washington, D.C.), 52(11), 1533-1534.

O'Reilly, R. L., Keegan, D. L. and Elias, J. W. (2000). A survey of the use of community treatment orders by psychiatrists in Saskatchewan. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 45(1), 79-81.

Ozgul, S. and Brunero, S. (1997). A pilot study of the utilisation and outcome of community orders: Client, carer, case manager and mental health review tribunal perspective. *Australian Health Review: A Publication of the Australian Hospital Association*, 20(4), 70-83.

Phillips, S. D., Burns, B. J., Edgar, E. R., Mueser, K. T., Linkins, K. W. and Rosenheck, R. A. et al. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services* (Washington, D.C.), 52(6), 771-779.

Preston, N. J., Kisely, S. and Xiao, J. (2002). Assessing the outcome of compulsory psychiatric treatment in the community: Epidemiological study in Western Australia. *BMJ (Clinical Research Ed.)*, 324(7348), 1244.

Quinlivan, R. T. (2000). Treating high-cost users of behavioral health services in a health maintenance organization. *Psychiatric Services* (Washington, D.C.), 51(2), 159-161.

Reed, D. B. (2000). Outpatient civil commitment: A growing trend in state law. *Community Health Report*, 1(1)

Ridgely, M. S. (2003). Outpatient commitment: Laura's law and the Rand report. *Psychiatric Services* (Washington, D.C.), 54(4), 575-576.

Ridgely, M. S., Borum, R. and Petrila, J. RAND Health, RAND Institute for Civil Justice, and California. Legislature. Senate. Rules Committee. (2001). *The effectiveness of involuntary outpatient treatment: Empirical evidence and the experience of eight states*. Santa Monica, Calif.: RAND Health; RAND Institute for Civil Justice.

Roberts, C. A. (1989). Viewpoint: Development of mental health services and psychiatry in Canada: Lessons from the past: Problems of the present; and the future. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 34(4), 291-298.

Robinson, J. and Mahmood, T. (2004). Compulsory community treatment and admission rates. *The British Journal of Psychiatry; the Journal of Mental Science*, 185, 519; author reply 519-20.

Rolfe, T. (2001). *Community Treatment Orders: A Review*: Office of the Chief Psychiatrist, Department of Health, Western Australia. Retrieved from http://www.health.wa.gov.au/mhareview/resources/documents/A_Review_of_CTOs_T_Rolfe.pdf

Romans, S., Dawson, J., Mullen, R. and Gibbs, A. (2004). How mental health clinicians view community treatment orders: A national New Zealand survey. *The Australian and New Zealand Journal of Psychiatry*, 38(10), 836-841.

Schmidt, M. J. and Geller, J. L. (1989). Involuntary administration of medication in the community: The judicial opportunity. *The Bulletin of the American Academy of Psychiatry and the Law*, 17(3), 283-292.

Segal, S. P. (2001). Effectiveness of involuntary outpatient commitment. *The American Journal of Psychiatry*, 158(4), 654-656.

Sensky, T., Hughes, T. and Hirsch, S. (1991). Compulsory psychiatric treatment in the community. I. A controlled study of compulsory community treatment with extended leave under the mental health act: Special characteristics of patients treated and impact of treatment. *The British Journal of Psychiatry; the Journal of Mental Science*, 158, 792-9, 804.

Sensky, T., Hughes, T. and Hirsch, S. (1991). Compulsory psychiatric treatment in the community. II. A controlled study of patients whom psychiatrists would recommend for compulsory treatment in the community. *The British Journal of Psychiatry; the Journal of Mental Science*, 158, 799-804.

Silfen, P. and Levy, A. (1995). Forensic psychiatry in Israel: Involuntary out-patient treatment. *The Israel Journal of Psychiatry and Related Sciences*, 32(2), 79.

Slobogin, C. (1994). Involuntary community treatment of people who are violent and mentally ill: A legal analysis. *Hospital and Community Psychiatry*, 45(7), 685-689.

Smith, C. A. (1995). Use of involuntary outpatient commitment in community care of the seriously and persistently mentally ill patient. *Issues in Mental Health Nursing*, 16(3), 275-284.

Steadman, H. J., Gounis, K., Dennis, D., Hopper, K., Roche, B. and Swartz, M. et al. (2001). Assessing the New York City involuntary outpatient commitment pilot program. *Psychiatric Services* (Washington, D.C.), 52(3), 330-336.

Stein, L. I. and Diamond, R. J. (2000). Commentary: A systems-based alternative to mandatory outpatient treatment. *The Journal of the American Academy of Psychiatry and the Law*, 28(2), 159-164.

Stroup, T. S., McEvoy, J. P., Swartz, M. S., Byerly, M. J., Glick, I. D. and Canive, J. M. et al. (2003). The national institute of mental health clinical antipsychotic trials of intervention effectiveness (CATIE) project: Schizophrenia trial design and protocol development. *Schizophrenia Bulletin*, 29(1), 15-31.

Swanson, J. W., Swartz, M. S., Borum, R., Hiday, V. A., Wagner, H. R. and Burns, B. J. (2000). Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *The British Journal of Psychiatry; the Journal of Mental Science*, 176, 324-331.

Swanson, J. W., Swartz, M. S., Elbogen, E. B., Wagner, H. R. and Burns, B. J. (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law*, 21(4), 473-491.

Swanson, J. W., Swartz, M. S., George, L. K., Burns, B. J., Hiday, V. A. and Borum, R. et al. (1997). Interpreting the effectiveness of involuntary outpatient commitment: A conceptual model. *The Journal of the American Academy of Psychiatry and the Law*, 25(1), 5-16.

Swanson, J. W., Tepper, M. C., Backlar, P. and Swartz, M. S. (2000). Psychiatric advance directives: An alternative to coercive treatment? *Psychiatry*, 63(2), 160-172.

Swartz, M., and Morrissey, J. (2003). Mental health care in North Carolina: Challenges on the road to reform. *North Carolina Medical Journal*, 64(5), 205-211.

Swartz, M. S., Burns, B. J., Hiday, V. A., George, L. K., Swanson, J. and Wagner, H. R. (1995). New directions in research on involuntary outpatient commitment. *Psychiatric Services*. Washington, D.C. Retrieved from *http://ps.psychiatryonline.org/cgi/content/abstract/46/4/381*.

Swartz, M. S. and Monahan, J. (2001). Special section on involuntary outpatient commitment: Introduction. *Psychiatric Services* (Washington, D.C.), 52(3), 323-324.

Swartz, M. S. and Swanson, J. W. (2004). Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: What's in the data? *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 49(9), 585-591.

Swartz, M. S., Swanson, J. W. and Hannon, M. J. (2003). Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals. *Behavioral Sciences and the Law*, 21(4), 459-472.

Swartz, M. S., Swanson, J. W., Hiday, V. A., Wagner, H. R., Burns, B. J. and Borum, R. (2001). A randomized controlled trial of outpatient commitment in North Carolina. *Psychiatric Services* (Washington, D.C.), 52(3), 325-329.

Swartz, M. S., Swanson, J. W., Wagner, H. R., Burns, B. J. and Hiday, V. A. (2001). Effects of involuntary outpatient commitment and depot antipsychotics on treatment adherence in persons with severe mental illness. *The Journal of Nervous and Mental Disease*, 189(9), 583-592.

Swartz, M. S., Swanson, J. W., Wagner, H. R., Burns, B. J., Hiday, V. A. and Borum, R. (1999). Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. *The American Journal of Psychiatry*, 156(12), 1968-1975.

Swartz, M. S., Swanson, J. W., Wagner, H. R., Hannon, M. J., Burns, B. J. and Shumway, M. (2003). Assessment of four stakeholder groups' preferences concerning outpatient commitment for persons with schizophrenia. *The American Journal of Psychiatry*, 160(6), 1139-1146.

Swartz, M. S., Wagner, H. R., Swanson, J. W. and Elbogen, E. B. (2004). Consumers' perceptions of the fairness and effectiveness of mandated community treatment and related pressures. *Psychiatric Services* (Washington, D.C.), 55(7), 780-785.

Swartz, M. S., Wagner, H. R., Swanson, J. W., Hiday, V. A. and Burns, B. J. (2002). The perceived coerciveness of involuntary outpatient commitment: Findings from an experimental study. *The Journal of the American Academy of Psychiatry and the Law*, 30(2), 207-217.

Switzky, H. N. and Miller, T. L. (1978). The least restrictive alternative. *Mental Retardation*, 16(1), 52-54.

Szigeti, A. (2001). Ontario's community treatment orders: How did we get there and where do we go now? an advocate's perspective. *Health Law in Canada*, 21(3), 66-83.

Szigeti, A. and Hiltz, D. (2004). *A guide to consent and capacity law in Ontario*. Markham, Ont.: LexisNexis Butterworths.

Szmukler, G. and Holloway, F. (2000). Reform of the mental health act. health or safety? *The British Journal of Psychiatry; the Journal of Mental Science*, 177, 196-200.

Szmukler, G. and Hotopf, M. (2001). Effectiveness of involuntary outpatient commitment. *The American Journal of Psychiatry*, 158(4), 653-654.

Szmukler, G. I., Bird, A. S. and Button, E. J. (1981). Compulsory admissions in a London borough: I. social and clinical features and a follow-up. *Psychological Medicine*, 11(3), 617-636.

Taipale, V. (2001). Mental health and quality of mental health care. *Medicine and Law*, 20(4), 531-542.

Thornicroft, G. (1987). Compulsory treatment in the community for the mentally ill? *British Medical Journal (Clinical Research Ed.)*, 295(6612), 1562-1563.

Torrey, E. F. and Kaplan, R. J. (1995). A national survey of the use of outpatient commitment. *Psychiatric Services* (Washington, D.C.), 46(8), 778-784.

Torrey, E. F. and Zdanowicz, M. (2001). Outpatient commitment: What, why, and for whom. *Psychiatric Services* (Washington, D.C.), 52(3), 337-341.

Trueman, S. (2003). Community treatment orders and Nova Scotia – the least restrictive alternative? *Health Law Journal*, 11, 1-33.

Urmer, A. H. (1975). Implications of California's new mental health law. *The American Journal of Psychiatry*, 132(3), 251-254.

Van Putten, R. A., Santiago, J. M. and Berren, M. R. (1988). Involuntary outpatient commitment in Arizona: A retrospective study. *Hospital and Community Psychiatry*, 39(9), 953-958.

Vaughan, K., McConaghy, N., Wolf, C., Myhr, C. and Black, T. (2000). Community treatment orders: Relationship to clinical care, medication compliance, behavioural disturbance and readmission. *The Australian and New Zealand Journal of Psychiatry*, 34(5), 801-808.

Vermont. Supreme Court. (1986). In re G.K. *Atl.Report*, 514, 1031-1034.

Wilk, R. J. (1988). Involuntary outpatient commitment of the mentally ill. *Social Work*, 33(2), 133-137.

Xiao, J., Preston, N. J. and Kisely, S. (2004). What determines compulsory community treatment? A logistic regression analysis using linked mental health and offender databases. *The Australian and New Zealand Journal of Psychiatry*, 38(8), 613-618.

9.2 Interview Locations

Ajax	Hamilton	Oshawa
Barrie	Hawkesbury	Ottawa
Belleville	Horseshoe Valley (CTO conference)	Owen Sound
Bracebridge	Kenora	Pembroke
Brampton	Kington	Penetanguishene
Brantford	Kitchener/Waterloo	Peterborough
Brockville	Lindsay	Sarnia
Campbellford	London	St. Catharines
Casselman	Markham	Sault Ste. Marie
Chathan	Midland	Sudbury
Cornwall	Mississauga	Thunder Bay
Durham	Newmarket	Toronto
Elliott Lake	Niagara Falls	Welland
Guelph	North Bay	Whitby
Haliburton	Orillia	Windsor

9.3 The Survey

COMMUNITY TREATMENT ORDERS:
ONTARIO LEGISLATED REVIEW
INDIVIDUAL SURVEY

Hello

The Community Treatment Orders Ontario Legislated Review invites you to participate in this survey. For more information about the Review I please consult our website at www.ctoproject.ca. Anyone with an interest in community treatment orders is encouraged to complete this survey. NOTE: the survey is intended for individual input to the Review, not for organizations – although individuals working for organizations are encouraged to complete the survey. Check our website for a template for organizations to submit comments.

While the website has a printable version available for persons without access to the Internet, if at all possible please use the online survey rather than submitting a printed survey.

It will take approximately 20 minutes to complete the survey. Please do not submit more than one survey. It is very important for us to receive as many opinions as possible and we appreciate your time and effort. Your survey responses will be coded and will remain strictly confidential. The data from this survey will be reported only in the aggregate. No individuals will be identified. For more information, please refer to the privacy policy on our website at www.ctoproject.ca.

If you feel uncomfortable answering the questions, you can withdraw from the survey at any point.

If you have questions at any time about the surveyor the procedures, you may contact us by e-mail at survey@ctoproject.ca. Thank you very much for your time and support.

All printed surveys must be returned by April 30, 2005 in order to be tabulated and includes in the survey analysis.

PART 1 – INFORMATION ABOUT YOU

My gender is: ☐ Male ☐ Female

My age is: ☐ 0-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 81+

The first three digits of the postal code of my workplace
(or residence if you are not employed in the mental health system) are: ☐☐☐

Which of the following best describes your interest in CTOs:

☐ Consumer – Survivor
☐ Psychiatrist
☐ Other Physician
☐ CTO Coordinator
☐ Substitute Decision-Maker (SDM)
☐ Family/Friend
☐ Rights Adviser
☐ Community Mental Health Worker
☐ Inpatient Mental Health Worker
☐ Mental Health Researcher
☐ Lawyer
☐ Consumer Advocate
☐ Consent and Capacity Board Member
☐ Government
☐ Student
☐ Police
☐ Other (Please Indicate)

PART 2 – INVOLVEMENT WITH CTOs

Have you signed a CTO or community treatment plan as a physician, substitute decision-maker (SDM), consumer-survivor, community mental health worker or other health practitioner or have you been the subject of a CTO?

☐ Yes ☐ No

If the answer to the previous question was Yes, please indicate how many CTOs (the total of issues, renewals, and reissues) you have signed or been the subject of? _____

If your answer to the previous question was *No*, please briefly describe your experience and the number of CTOs (the total of issues, renewals and reissues), if any, in which you have indirectly participated.

_____

_____

If you have ever been the subject of a CTO, who provided consent?

☐ Not Applicable ☐ Yourself ☐ Substitute Decision-Maker (SDM)

PART 3 – FACTORS AFFECTING THE USE OF CTOs

How important are the following factors in limiting the use of CTOs in Ontario?
Mark the five you consider the most important in limiting the use of CTOs.

- ☐ Level of knowledge and/or experience with CTOs
- ☐ Concerns regarding infringement of patient rights
- ☐ Issues related to rights advice
- ☐ Workload concerns regarding issuing a CTO, the legal review process and/or
- ☐ Supervising a CTO client
- ☐ Insufficient community resources available for clients on CTOs
- ☐ Concerns regarding compensation and/or liability
- ☐ Potential negative impact on rapport between client and their service provider
- ☐ New LOA provisions under the *Mental Health Act* are a simpler alternative
- ☐ Refusal of consent by SDM or client
- ☐ Limited enforcement mechanisms available
- ☐ CTOs are only useful for a limited client population
- ☐ Lack of scientific evidence

How important are the following factors in supporting or encouraging the use of CTOs in Ontario?
Mark the five you consider the most important in encouraging the use of CTOs.

- ☐ Access to additional resources like case management
- ☐ Addressing treatment non-compliance
- ☐ Reducing frequency of hospitalizations
- ☐ Ensuring a team supported community treatment plan
- ☐ Availability of CTO Coordinators
- ☐ Client request
- ☐ Meeting legislated criteria
- ☐ Assurance that rights are protected
- ☐ Safety in the community
- ☐ Family or SDM request

PART 4 – OPINIONS ABOUT CTOs

We are eager to learn as much as possible from you about your opinions on CTOs. Some of the following questions may not apply to you. In that case, or if you have no opinion about a question, skip over the question and move on to the next one. This is the last section of the survey. It should only take about ten minutes to complete. These answers will assist us in identifying issues that need more attention and aspects of CTOs that appear to be working well.

Select:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
CTOs are an effective way of addressing the "revolving door" between the hospital and the community	☐	☐	☐	☐	☐
The Rights Advice process tends to delay the issuing of CTOs	☐	☐	☐	☐	☐
Compensation, liability and paperwork issues deter physicians from using CTOs	☐	☐	☐	☐	☐
The use of CTOs has not reduced hospital readmission rates or lengths of stay for CTO clients	☐	☐	☐	☐	☐
CTO clients maintain their gains after the CTO expires	☐	☐	☐	☐	☐
Physicians tend to avoid findings of incapacity and second renewals in order to avoid the Consent and Capacity Board	☐	☐	☐	☐	☐
The CTO program is effectively serving the aboriginal, rural, multi-cultural and francophone communities	☐	☐	☐	☐	☐
Rights Advice accommodates the differing needs of substitute decision-makers, incapable patients and capable patients	☐	☐	☐	☐	☐
CTOs keep people out of hospital	☐	☐	☐	☐	☐
Rights Advice should also be available after the CTO is issued	☐	☐	☐	☐	☐
CTOs could be effective in keeping people out of the criminal justice system	☐	☐	☐	☐	☐
CTOs take needed resources away from non-CTO clients	☐	☐	☐	☐	☐
CTOs are being used as a way to get to the front of the resource line	☐	☐	☐	☐	☐
CTO coordinators need more resources and guidance	☐	☐	☐	☐	☐
CTO treatment outcomes are being adequately evaluated	☐	☐	☐	☐	☐
CTOs "lack teeth" and are difficult to enforce	☐	☐	☐	☐	☐
Mental health professionals are fully aware of the new Leave of Absence provisions	☐	☐	☐	☐	☐
CTOs are effective in reducing the risk of serious harm to people in the community	☐	☐	☐	☐	☐
CTOs have better outcomes than other community treatment options	☐	☐	☐	☐	☐
CTOs have a positive impact on quality of life	☐	☐	☐	☐	☐
The civil rights of CTO clients are adequately protected	☐	☐	☐	☐	☐
CTOs increase communication and understanding among service providers	☐	☐	☐	☐	☐
The legal safeguards in the legislation are excessive	☐	☐	☐	☐	☐

PART 4 – OPINIONS ABOUT CTOs continued

Select:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
There is a group of underserviced clients who could be helped by a CTO but who do not meet the existing criteria	☐	☐	☐	☐	☐
Physicians are adequately educated and informed about CTOs and related issues	☐	☐	☐	☐	☐
There should be more research on the appropriate use and outcomes of CTOs	☐	☐	☐	☐	☐
The availability of income support and housing influences the effectiveness of CTOs	☐	☐	☐	☐	☐
The Consent and Capacity Board process is satisfactory for all stakeholders	☐	☐	☐	☐	☐
Rights advisers overstep their mandate	☐	☐	☐	☐	☐
The CTO program does not address the unique needs of my area of the province	☐	☐	☐	☐	☐
The legislation appropriately balances the need for treatment, care and protection with clients' liberty interests	☐	☐	☐	☐	☐
The requirement that CTO candidates must meet the Form 1 criteria is not justified	☐	☐	☐	☐	☐
CTOs should be a last resort when other treatment options have been explored	☐	☐	☐	☐	☐
The methods for dealing with noncompliance are satisfactory	☐	☐	☐	☐	☐
Rights advice provisions do not adequately protect consumers and families	☐	☐	☐	☐	☐

Thank you for taking the time to complete this survey.
Please mail no later than April 30, 2005.

9.4 MOHLTC planning regions

Region	County Name
Central East	Durham Regional Municipality Haliburton County Northumberland County City of Kawartha Lakes Peterborough County Simcoe County York Regional Municipality
Central South	Brant County Haldimand-Norfolk Regional Municipality City of Hamilton Niagara Regional Municipality
Central West	Halton Regional Municipality Peel Regional Municipality Waterloo Regional Municipality Dufferin County Wellington County
East	Prescott and Russell United Counties Stormont, Dundas and Glengarry United Counties Hastings County Prince Edward County Frontenac County Lennox and Addington County Lanark County Leeds and Grenville United Counties City of Ottawa Renfrew County
North	Algoma District Muskoka District Municipality Parry Sound District Nipissing District Kenora District Rainy River District Thunder Bay District Cochrane District Manitoulin District Sudbury District Sudbury Region Timiskaming District
Southwest	Kent County Elgin County Bruce County Grey County Huron County Lambton County Middlesex County Oxford County Perth County Essex County
Toronto	City of Toronto

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